

Best Practices Manual for Discharge Planning:

- *Mental Health &
Substance Abuse Facilities*
- *Hospitals*
- *Foster Care*
- *Prisons and Jails*



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Funded by a grant from The California Endowment

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Foreword



A significant majority of the homeless population in California and specifically, Los Angeles County are individuals who have recently been discharged from an institution or care facility. Specifically, according to the Los Angeles-based Economic Roundtable, 60% of homeless individuals and over 50% of families self report that they were discharged into homelessness either by a shelter, jail, hospital or other care facility. These individuals have been admitted to a system that has poor and

inadequate planning for their release. Consequently, they are “discharged to the streets,” either returned to homelessness or become homeless and their health and stability soon begins to deteriorate. According to the U.S. Interagency Council on Homelessness, “Institutional discharge is the process to prepare a person for return or reentry to the community by connecting the individual to essential community treatment, housing, and human services.”¹

The U.S. Interagency Council on Homelessness found in their 1994 report, *Priority Home!*, that persons with low-income and persons of color are more likely to “experience homelessness upon departure from a hospital, treatment facility, penal institution, or the foster care system.”²

These systems all lack comprehensive planning strategies which result in an increased likelihood that individuals exiting the system will become homeless. Equipped with little or no tools to ensure their successful reentry, they often become overwhelmed and have difficulty maintaining the gains made throughout treatment and placement.



¹ Interagency Council on Homelessness (IHC). *Priority Home: The Federal Plan to Break the Cycle of Homelessness*. 1994.

² Institutional Discharge Policy Statement, National Health Care for the Homeless Council, 2008.



The National Health Care for the Homeless Council outlined six recommendations for providers of mental health, health, penal institutions and foster care for the successful implementation of discharge and aftercare planning:

1. The plan should prevent consumers from falling into homelessness.
2. Identification of appropriate housing is critical.
 - Discharges to emergency shelters are inappropriate for any situation.
 - Discharges to homeless programs that have 24-hour transitional programs may be made on a case-by-case basis.
 - Discharges to supportive housing and/or halfway houses are beneficial.
3. Planning must be individualized, comprehensive and coordinated with community based services.
4. Consumers must participate in the planning.
5. Institution staff (inclusive of professional staff) and community partners should be included.
6. For consumers who abuse substances, appropriate treatment must be included.

As important as it is to institute these recommendations as well as those detailed in this manual, it is even more important to, in the short term, advocate for more respite facilities for homeless people in your community, and in the longer term, advocate for affordable housing in your community. “Discharging people to the streets” would not be an issue if there was enough permanent supportive housing and other affordable housing models for discharge planners to send their patients to.

The following chapters will discuss best practices for discharge planning in four of the institutions with severe shortcomings in Los Angeles; mental health and co-occurring disorder treatment facilities, hospitals, foster care and jails/prisons.

The chapters will include data on the scope of the problem in Los Angeles County, the value of conducting discharge planning, the elements to be included in planning, and will conclude with recommendations for providers.



Executive Summary

This manual presents the best practices in discharge planning with a focus on mental health and substance abuse facilities, hospitals, jails and prisons and the foster care system. It is not an end all solution to ending homelessness nor is it the ultimate guide for discharge planning.

There is only one thing that can end homelessness and that is to prevent it, and to prevent people from being “discharged to the streets” by the four institutions we will be discussing.

What this manual is, however, is a guide for discharge planners and administrators to effectively create and implement discharge plans. It does not offer answers to every situation or work to eliminate the crisis of homelessness.

It is a guide that will help you plan and implement effective discharge planning procedures in an effort to prevent your population from becoming homeless. This manual scratches the surface of the homeless crisis, but it is up to you, the provider, to advocate for homelessness prevention.

One of the biggest problems with discharge planning is that there is simply no where to discharge inmates, foster youth, and the mentally/physically ill to. There is an affordable housing crisis in Los Angeles and the nation in general, and a need to increase funding for supportive, transitional and affordable housing. Again, part of the uphill battle for discharge planners is finding somewhere for people to go, other than the streets or emergency shelters.

Without adequate affordable housing and supportive places for people to go, there lies a huge crisis—who will bear the burden of discharge planning? Hospitals have continuously argued that without these supportive services, their hands are tied and they often have no choice but to “dump” patients. Author Dr. Michael Cousineau has often criticized policy makers and the government for their lack of effort in regards to providing housing for the homeless. He is very critical of policy makers and believes that many of the cases we are now seeing against hospitals that dump and providers who do not discharge plan are nothing more than distractions from the underlying problem—the government has failed to provide for its homeless and needy. Policy makers need to be responsible for insuring housing and placements are available to those being discharged, but the responsibility for advocating and demanding such locations is a shared responsibility between all of us.



Los Angeles City is a tale of “2 cities;” One very wealthy and the other of deep poverty, destitution and homelessness. Los Angeles City has the largest divide between low-income people and wealthy people than any city in the nation. In addition, Los Angeles has the disgrace of being the “homeless capital” of America, with nearly 80,000 homeless people on any given night, with approximately half of that figure being in LA City. In fact, in 2007, Los Angeles met its housing construction goals, building over 12,000 units of housing. Sadly, however, over 90% of this housing was for people with incomes of \$135,000 and above. Los Angeles policymakers clearly have no intention of addressing the crisis of affordable housing for middle and low-income people, let alone preventing and ending homelessness.

Finally, we need solid working relationships between agencies providing services and housing, and the institutions doing the releasing so that all our discharge efforts are more effective. For Los Angeles, that means a partnership between Los Angeles; City and Los Angeles County, who historically would rather sue or ignore each other than partner on projects that combine affordable housing [LA City] with the services people need [LA County].

Whether this means shuffling around the money already allocated to such programs to work more effectively together, or creating an entirely new plan—creating new relationships and partnerships and a collective effort are essential.

Special thanks to members of our focus group, Paul Freese of Public Counsel, Casey Horan, the Executive Director of LAMP Community and Dr. Jacqueline McCroskey, Professor, School of Social Work, University of Southern California

This manual was funded by a grant from The California Endowment.



Chapter One: Discharge Planning for Mental Health and Substance Abuse Facilities

There is ample evidence that mental health, substance abuse and co-occurring (i.e. substance abuse and mental health) providers are doing a poor job of planning for the discharge of clients from their system of care into that of others. This problem is not unique to the mental health and substance abuse treatment fields as discharge planning seems to be poorly planned and executed in multiple systems of care. Highlighted by Sowers and Rohland, “..fragmentation in systems of care has been common, and the transition from one provider, location, or intensity of services to another has not been prioritized in treatment planning.”³ For individuals with co-occurring disorders, the problem of poor discharge planning and ensuing difficulties are aggravated as they are dealing with more than one health issue.

Either way, clients are the ones that suffer as they experience fragmentation, discontinuity of care, and a lack of communication and coordination among the various services that they may require in the community. Ultimately, poor discharge planning negatively impacts any health gains the client may have experienced while in care and leads to a revolving door phenomenon which is discouraging both to providers and clients alike.

In principle, most agree that discharge planning is an important element of care and a critical activity in the delivery of continuity of care for all clients. As providers, we want to feel that our programs and services are having their intended impact of improving the health status of our clients. What appears to be lacking is a common understanding of discharge planning that is appropriate for clients dealing with substance abuse, mental health, and co-occurring issues as well as uniform principles and guidelines for implementation.

The following sections present information in regards to the scope of the problem, value of conducting discharge planning, models of discharge planning, elements and guidelines in terms of who needs to be involved in discharge planning, recommendations for providers, and will provide examples of model programs. Appendices A and B include a template of a discharge plan and a discharge plan checklist.

³ Sowers WE, Rohland B, American Association of Community Psychiatrists’ Principles for Managing Transitions in Behavioral Health Services, Psychiatric Services, <http://ps.psychiatryonline.org>, November 2004, Vol. 55, No.11.



Scope of Problem & Data Elements

Mental Health An estimated 26.2 percent (approximately 57.7 million) of Americans ages 18 and older — about one in four adults — suffer from a diagnosable mental disorder in a given year. According to the 2004 US Census residential population, there are an estimated 57.7 million Americans affected by mental health. Even though mental disorders are widespread in the population, the main burden of illness is concentrated in a much smaller proportion — about 6 percent, or 1 in 17 — who suffer from a serious mental illness. In addition, mental disorders are the leading cause of disability for ages 15-44 in the U.S. Nearly half (45 percent) of those with any mental disorder meet criteria for 2 or more disorders, with severity strongly related to co-morbidity.⁴ According to the National Health Interview Survey, in terms of non-institutionalized adults (age 18 years and older) experiencing serious psychological distress in last 30 days, women tended to have higher rates than men and those between the age of 45 and 64 had higher rates as compared to all other age groups. In terms of race/ethnicity, Latinos ranked the highest among all racial/ethnic groups.⁵

About 6 percent, or 1 in 17 people suffer from a mental illness.

There are an estimated 57.7 million Americans affected by mental illness.

Nationally the most common mental disorders are associated with Mood Disorders (e.g. major depressive disorder, dysthymic disorder, bipolar disorder and suicide), Schizophrenia, Anxiety Disorders (e.g. panic disorder, post-traumatic stress disorder (PTSD), and generalized anxiety disorder), Eating Disorders, Attention Deficit Hyperactivity Disorder, Autism and Alzheimer's Disease.

Obtaining treatment for mental disorders is crucial to maintaining overall health. The U.S. Surgeon General strongly recommends that anyone who has a mental health problem or symptoms of a mental disorder seek help, since treatment for mental disorders can be highly effective. However, less than one in three persons with a mental disorder receives treatment.

4 NIH <http://www.nimh.nih.gov/health/publications/the-numbers-count-mental-disorders-in-America.shtml>

5 Early release of selected estimates based on data from the National Health Interview Survey, data Table for figure 13.1, March 2008 http://www.cdc.gov/nchs/data/nhis/earlyrelease/200803_13.pdf

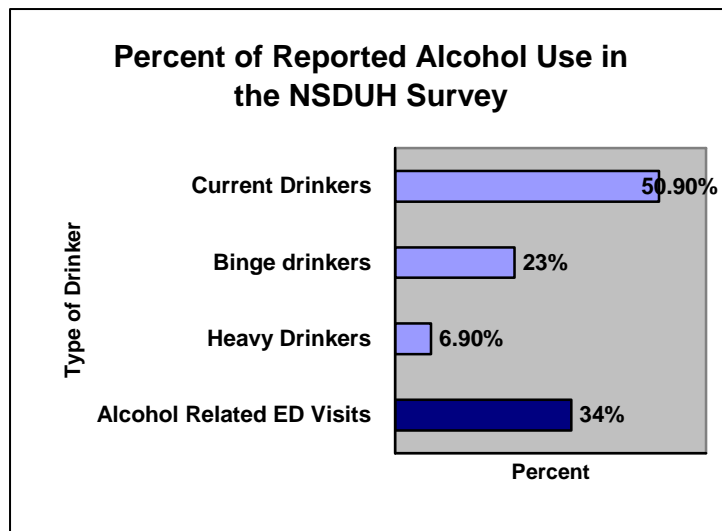


Common barriers associated with receiving mental health treatment include:

- Service is simply unavailable, particularly in low income communities and/or rural areas.
- Lack of awareness of location of services and familiarity with how to access needed care.
- Lack of insurance coverage or perceived cost of mental health services.
- Lack of access to appointments in a timely manner.
- Stigma associated with accessing services.
- Poor quality of care and/or care not available in individuals preferred language (e.g. non-English).
- Lack of appropriate assessment that establishes that individual primary problem might be a mental health issue
- Misdiagnosis by mental health providers which leads to inappropriate type of care and medications

Substance Abuse The most common used and abused substance nationally, is alcohol. According to the NSDUH Survey, an estimated 125 million (50.9%) Americans aged 12 or older reported being current drinkers of alcohol. Of these current drinkers, 57 million (23%) persons aged 12 or older reported binge drinking (i.e. having five or more drinks on the same occasion on at least 1 day in the 30 days prior to the survey) and 17 million (6.9%) reported

Some studies report 50-85 percent of homeless individuals struggle with drug and alcohol abuse.

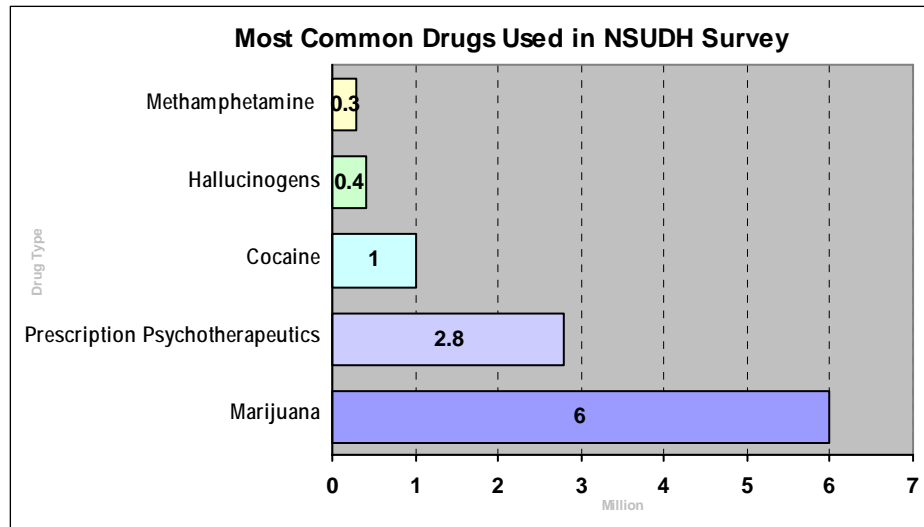


heavy drinking (i.e. binge drinking on at least 5 days in the past 30 days) in 2006.⁶ In terms of hospitals and emergency departments, alcohol-related ED visits accounted for 34% of all drug misuse or drug abuse ED visits. Alcohol was most frequently combined with cocaine alone (86,482 visits), marijuana alone (33,643 visits), cocaine and marijuana (22,377 visits), and heroin alone (12,797 visits).

6 Results from the 2006 National Survey on Drug Use and Health: National Findings, Office of Applied Studies, September 2007
<http://oas.samhsa.gov/nsduh/2k6nsduh/2k6Results.cfm#TOC>



The 2006 National Survey on Drug Use and Health (NSDUH) Survey also found that an estimated 20.4 million Americans aged 12 or older were current (past month) illicit drug users, meaning they had used an illicit drug during the month prior to the survey interview, representing 8.3% of the population aged 12 years old or older. Illicit drugs include marijuana/hashish, cocaine (including crack), heroin, hallucinogens, inhalants,



or prescription-type psychotherapeutics used non-medically. Marijuana was the most commonly used illicit drug (14.8 million past month users) among persons aged 12 or older, the rate of past month marijuana use was 6% in 2006. In addition, 2.4 million (1%) individuals age 12 or older were

identified as current cocaine users aged 12 or older; 1 million (0.4%) used Hallucinogens (including 528,000 who had used Ecstasy); 7 million (2.8%) persons used prescription-type psychotherapeutic drugs non-medically in the past month and of these 5.2 million used pain relievers. The survey also found 731,000 (0.3%) current users of methamphetamine aged 12 or older. Alcohol/drug abuse disorders are also very common among homeless individuals with some studies reporting and incidence that ranges from 50 to 85 percent.⁷

⁷ Substance Abuse and Mental Health Services Administration, Blueprint for Change: Ending Chronic Homelessness for Persons with Serious Mental Illness and Co-Occurring Substance Use Disorders, 2003.



Scope of Problem in Los Angeles County

During the 2005-06 Fiscal Year, most of the alcohol/drug treatment and recovery program participants in Los Angeles County were male (65.4%); Hispanic/Latino (34.2%), White (29.8%), or Black/African American (25.4%); between 25 and 44 years of age (57.5%); had 9 to 12 years of education (75.4%); and unemployed (68.4%). Participants with positive compliance are those who completed treatment or left before completing treatment

Homeless participants reporting mental health concerns increased from 15% to 23% over a 5 year period.

with satisfactory progress. Over half of the program participants had positive treatment outcomes throughout four out of five fiscal years (2001-02 to 2005-06). The five year-year average for positive treatment compliance was 52.3%.

Additionally, a total of 49,950 homeless participants have been admitted to Alcohol Drug Programs Administration (ADPA)-funded alcohol and drug treatment and recovery programs over the last five fiscal years (2001-02 to 2005-06). The percent of homeless participants reporting mental health concerns has increased slightly over the five-year period, from 15.0% in 2001-02 to 23.3% in

2005-06. The most prominent drug problems reported by homeless participants were methamphetamine (30.7%), cocaine/crack (28.8%), and alcohol (19.0%). Each fiscal year, the majority (56.4% to 62.3%) of homeless participants successfully complied with their treatment plan.⁸

A total of 49,950 homeless participants have been admitted to one of the Alcohol - Drug Programs Administration funded

Individuals with co-occurring mental health and substance abuse problems participating in treatment in Los Angeles County more than doubled over fiscal years 2001-02 and 2005-06. During the time, total participants jumped from 5,632 to 12,263 in fiscal year 2005-06. Of all participants in co-occurring disorder programs, 56.4% were male and 43.6% were female. Approximately 40% individuals with co-occurring disorders were White, 30% African American, and 20.6% were Hispanic/Latino. More than half of these cases aged between 25 and 44, and 35.2% aged between 45 and 64. Seventy-two percent of them were unemployed, and 20% were not in the labor force. More than 75% reported being homeless in fiscal year 2005-06. During the same period, 6,447 individuals with co-occurring disorders were discharged from treatment programs. More than half (54.8%) of them reported positive compliance; however, 45.2% did not comply with treatment. Among those with positive compliance, only 34.4% completed treatment.⁹

⁸ Source: LA ADPA, page iii & vi http://www.lapublichealth.org/adpa/annualreview/AR_2005-06_FY.pdf

⁹ Source: LA ADPA, page 29 & 30 http://www.lapublichealth.org/adpa/annualreview/AR_2005-06_FY.pdf



Access and availability continues to represent a significant barrier in treating individuals with an alcohol/drug problem. In 2006, 23.6 million persons aged 12 or older needed treatment for an illicit drug or alcohol use problem (9.6% of the persons aged 12 or older). Of these, 2.5 million (1.0% of persons aged 12 or older and 10.8 percent of those who needed treatment) received treatment at a specialty facility. Thus, 21.1 million persons (8.6% of the population aged 12 or older) needed treatment for an illicit drug or alcohol use problem but did not receive treatment at a specialty substance abuse facility in the past year. The five most often reported reasons for not receiving illicit drug or alcohol use treatment among persons who needed but did not receive treatment at a specialty facility and perceived a need for treatment were:

- (1) not ready to stop using (37.2%);
- (2) no health coverage and could not afford cost (30.9%);
- (3) possible negative effect on job (13.3%);
- (4) not knowing where to go for treatment (12.6%); and
- (5) concern that it might cause neighbors/community to have negative opinion (11.0%).¹⁰

¹⁰ Results from the 2006 National Survey on Drug Use and Health: National Findings, Office of Applied Studies, September 2007
<http://oas.samhsa.gov/2k6/2k6nsduh/2k6Results.cfm#TOC> and <http://www.oas.samhsa.gov/NSDUH/2k5NSDUH/2k5Results.htm>



Value of Conducting Discharge Planning

Discharge planning should commence upon client admission into a service and/or program and the discharge plan should continue to be updated during the course of the client's treatment stay with the provider. The benefits of conducting discharge planning for clients with substance abuse, mental health or co-occurring issues are:

- to link clients to appropriate next step resources based on their needs;
- to minimize likelihood that client will “relapse” or have to return to care post successful completion of treatment;
- to prevent vulnerable clients from becoming homeless and/or criminalized; and
- to assist clients with re-entry to community.

Discharge planning is important in order to maintain gains achieved during the course of treatment the client has had in the inpatient, residential and/or outpatient care setting. Conversely, lack of discharge planning can cause an interruption in the care of the client, one of the most significant obstacles to establishing a stable recovery. Clients impacted by mental health, substance abuse or co-occurring disorders leaving a treatment program will most likely have a number of continuing health care issues that will need to be addressed.

The client may still be in need of self-help groups, relapse prevention groups, continued individual counseling, mental health services (especially important for clients who will continue to require medication), as well as intensive case management monitoring and support. A carefully developed discharge plan, produced in collaboration with the client, will identify and match client needs with community resources, providing the support needed to sustain the progress achieved during treatment.

Priority Home! recognized that inadequate discharge planning can contribute to homelessness among people with serious mental illnesses and/or substance use disorders. If discharge planning is done correctly it can help prevent homelessness but also have the following benefits: 1) ensure that clients with mental health, substance abuse or those with co-occurring disorders are appropriately identified; and 2) support the further integration of systems of care for purposes of facilitating the treatment of such clients at the appropriate intensity and needed type of care. The biggest challenge is that presently, clients are discharged without being appropriately identified (or are misidentified) and as a result they are inappropriately being treated and referred for on-going care.¹¹

¹¹ Essential Resources for Discharge Planning, National Health Care for the Homeless Council, 2002.



Discharge Planning Model

An integrated model of treatment for clients with co-occurring disorders requires that each member of the treatment team has substantial competency in both fields. In addition, the staff should be prepared to address co-occurring disorders as a norm of their service delivery versus as the exception. This may be complicated by the fact that while the substance abuse and mental health field share many common elements, they remain two separate fields with their own unique service approach, preferred evidence based practices, language and even varying definitions for commonly used terms. For these reasons, both mental health and substance abuse treatment staff requires initial training, cross-training, and on-the-job supervision to adequately meet the needs of clients with co-occurring disorders.

Within substance abuse treatment settings, this means training in these areas:

- Recognizing and understanding the symptoms of the various mental disorders
- Understanding the relationship between different mental symptoms, drugs of choice, and treatment history
- Individualizing and modifying approaches to meet the needs of specific clients and achieve treatment goals
- Accessing services from multiple systems and negotiating integrated treatment plans

Conversely, in mental health settings, this means training in the following areas:

- Basic definitions of substance abuse and addiction
- Common signs and symptoms of drug abuse and/or addiction to substances
- Understanding the interaction and potential side effects associated with commonly prescribed mental health medications and commonly abused drugs and/or substance
- Role of self-help groups such as Alcoholics Anonymous, Cocaine Anonymous and/or Narcotics Anonymous.

Staff should be consistently reminded that there is no one correct co-occurring discharge planning approach but that instead the emphasis should be placed on individualized planning reflective of the client's on-going need for services.



Who Should be Involved in Discharge Planning?

Discharge planning is a team approach that should include the client and when appropriate family members. The treatment team of front line staff, including; psychologist, social worker, psychiatrist, counselor, case manager, vocational specialist, and housing professionals should participate in creating the discharge plan. In addition, the team should include the community partners of the client, such as peers, relatives, and friends. The consensus panel also recommends that programs working with clients with co-occurring disorders try to involve advocacy groups in program activities. These groups can help clients become advocates themselves, furthering the development and responsiveness of the treatment program while enhancing clients' sense of self-esteem and provide a source of affiliation.¹²

Elements of Successful Discharge Planning

Providers of substance abuse, mental health, and co-occurring services should adhere to the recommendations of the National Health Care for the Homeless Council¹³ in terms of elements to include in their discharge and aftercare plans. In addition:

- Discharge planning must be tailored for different needs of different clients- essentially it is important to create an Individual Service/Treatment Plan.
- Discharge planning needs to be comprehensive – this means that all the client's needs across multiple health systems should be addressed in the discharge plan.
- Discharge planning must create a system that is continuous and coordinated.
- Discharge planning for clients who abuse substances must include appropriate treatment, as such clients are more at risk for homelessness and criminalization.
- Next step resources are central to discharge planning. Without these resources, discharge planning is illusory.
- Lack of good discharge planning is often related to lack of appropriate options.
- Discharge plans must be practical and realistic and maximize available community resources for the benefit of the client.

¹²<http://www.ich.gov/innovations/1/III%20B%20Tools%20for%20Convening%20Conversations%20with%20Stakeholders.PDF>

¹³ Essential Resources for Discharge Planning, National Health Care for the Homeless Council, 2002.



Clients with co-occurring disorders often need a range of services besides substance abuse treatment and mental health services. Generally, prominent needs include housing and case management services to establish access to community health and social services. In fact, these two services are the *key factors for clients' successful recovery*. Without a place to live and some degree of economic stability, clients with co-occurring disorders are likely to return to substance abuse or experience a return of symptoms of mental disorder. Every substance abuse treatment provider should have, and many do have, the strongest possible linkages with community resources that can help address these and other client needs. It's important to remember that clients with co-occurring disorders often will require a wide variety of services that cannot be provided by a single program.

It is imperative that discharge planning for persons with co-occurring disorders ensures continuity of psychiatric assessment and medication management without which client stability and recovery will be severely compromised. Relapse prevention interventions after outpatient treatment need to be modified so that the client can recognize symptoms of psychiatric or substance abuse relapse on his/her own and can call on a learned repertoire of symptom management techniques, such as self-monitoring and group monitoring. This also includes the ability to access assessment services rapidly, since the return of psychiatric symptoms can often trigger substance abuse relapse.

Developing positive peer networks is another important facet of discharge planning for continuing care. The provider seeks to develop a support network for the client that involves family, community, recovery groups, friends, and significant others. Where a client's family of origin is not healthy and supportive, other networks can be accessed or developed that will support him. Programs also should encourage client participation in mutual self-help groups, particularly those that focus on co-occurring disorders. These groups can provide a continuing supportive network for the client, who usually can continue to participate in such programs even if he moves to a different community. Therefore, these groups are an important method of providing continuity of care.



Agencies and programs will need to identify and implement discharge forms that are appropriate for their client population, discharge accepting agencies/entities, and consistent with discharge agency policy and procedures. A review of the literature¹⁴, suggests that upon discharge, agencies should attempt to collect the following data elements:

- Reason for client's discharge
- Mental health/substance abuse treatment & service needs at discharge
- Services provided to client while in the care of discharge entity/agency
- Primary or significant problems/issues identified during treatment stay
- Assessment of client level of functioning
- Referrals provided for on-going mental health and/or substance abuse treatment
- Referrals provided for “recovery support” type of services
- Primary agency to which individual is being discharged to
- Other information related to client/patients achievement of treatment goals/outcomes.

¹⁴ Center for Substance Abuse Treatment, Identification of Clients with Co-Occurring Disorders in the Substance Abuse and Mental Health Treatment Systems, NEDS Fact Sheet #148, November of 2002.



Examples of Model Programs

The American Association of Community Psychiatrists which prefers to use the term “transition” versus “discharge planning” recommends that the following core elements be included as part of a discharge plan¹⁵:

Comprehensiveness- A transition plan includes all aspects of the client’s service needs across multiple health systems. Coordination of and collaboration among various elements of the service delivery system involved with the client on either side of the transition should be part of the treatment plan.

Individual Engagement- The client should be engaged in the discharge planning process and every effort should be made to elicit information on difficulties they anticipate in the transition process and their preferences. Also when appropriate, family members and other persons who provide support to the individual should be involved.

Responsiveness to Special Populations- The needs of special populations (e.g., co-occurring disorders) must be recognized, and transition plans must reflect those special needs. The plan must also be culturally sensitive.

Maximizing Resources- To be effective, transition plans must be practical and realistic and maximize the resources available to the client for purposes of continuing care and fostering self-reliance.

Relapse Prevention- Plans should also include a comprehensive relapse prevention component.

Clear Responsibilities- Protocols must clearly delineate responsibility for client care during transition and should encourage overlapping responsibilities between referring and receiving entities.

Contingency Plans and Tracking- People with co-occurring health issues should be carefully tracked as they navigate the various health systems to address to their needs and they should be made aware of the tracking plan. A process of re-engagement should be initiated whenever an unplanned alteration occurs in the plan.

Monitoring Outcomes- Quality indicators with measurable outcomes must be in place and outcomes must be monitored.

¹⁵ Ibid, pg. 18



Recommendations for Providers

There are several ways that providers can support effective discharge planning procedures. Following are some key recommendations:

1. If you don't already have one, establish a discharge planning work group that is reflective of the various departments/services provided by the agency.
2. Develop a uniform discharge planning process for individuals exiting your system of care. In a report prepared by Moran G., et al., they found that few programs have well-designed and integrated models of discharge planning processes and those that do have may not be implementing in a uniform and systematic manner.¹⁶
3. A critical first step of having a uniform discharge planning process would be to establish a written protocol for discharge planning which includes use of discharge forms.
4. If you already have a written protocol, revisit your discharge and aftercare policy and procedures and assess whether they are appropriate for individuals who are homeless or at risk of becoming homeless. For example, does the plan include linkages to appropriate housing and other community based care?
5. Provide training to all staff involved in discharge planning to ensure some degree of uniformity in the implementation of your written protocol. If resources allow, evaluate whether staff are following protocol and adhering to written guidelines.
6. Establish or determine who is in your wide network of "care providers" to whom you typically discharge and/or refer your clients.
7. Determine whether your wide network of care provider's policy and procedures for accepting discharges are consistent with your discharge policy and procedures.
8. If resources allow, collect data on outcomes of your discharge procedures. Attempt to collect data which allows you to assess whether the goal/purpose of your discharge procedure is being accomplished.

¹⁶ Moran G., et al., Evaluability Assessment of Discharge Planning and the Prevention of Homelessness: Final Report, Executive Summary, September 2005.



Chapter Two: Discharge Planning for Hospitals

The potential for patient “*dumping*” exists on both sides of hospital doors. Because of the Emergency Medical Treatment and Active Labor Act (EMTALA), passed by Congress in 1986 as part of the Consolidated Omnibus Budget Reconciliation Act¹⁷, hospitals and ambulance services must provide care to anyone needing emergency medical treatment regardless of citizenship, legal status or ability to pay. While the passage of this bill prohibited any hospital participating in Medicare or Medicaid payment services from refusing emergency medical treatment, it did ‘open the door’ for dumping into hospitals.

Group homes, convalescent homes, even family members could and do – with the passage of this bill – drop off the person needing medical treatment without fear of refusal. Indeed, the individual himself or herself could and does walk into an emergency room and receive medical treatment. EMTALA applies to emergency rooms only.¹⁸ Facilities not equipped to address medical emergencies are not obligated by EMTALA and can simply refer patients to the closest emergency room. The emergent medical crisis must be stabilized before discharge. Often this results in a hospital admission and thus the second possibility for *dumping* begins – dumping out of hospitals.

The EMTALA law contains no reimbursement provisions. How the participating hospitals receive payment is neither its focus nor its concern. Discharge from the admitting hospital can generally take place only when the patient is medically clear and gives informed consent for the discharge or when the patient must be transferred to a medical facility better equipped to administer appropriate treatment. Under EMTALA the facility to which the patient is transferred must accept the transfer thus extending the potential for dumping.

While passage of EMTALA has doubtlessly improved healthcare for those unable to afford health insurance or medical treatment, its passage has placed a tremendous financial burden on participating hospitals. Almost every hospital in this country is bound by the EMTALA laws. The result of these legally mandated financial pressures manifests in the consolidating or closing of hospitals and the corresponding over crowding of emergency rooms.

The following sections will present information in regards to the scope of the problem, value of conducting discharge planning, models of discharge planning, elements and guidelines in terms of who needs to be involved as well as recommendations for providers and examples of model programs.

¹⁷ Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985 (42 U.S.C. §1395dd).

¹⁸ American College of Emergency Physicians EMTALA Fact Sheet – <http://www.acep.org/patients.aspx?id=25936>



Scope of Problem & Data Elements

According to the Institute of Medicine, between 1993 and 2003 emergency room visits in this country grew by 26% while the country lost 425 emergency departments and 198,000 hospital beds. “Ambulances are frequently diverted from over crowded emergency rooms to other hospitals that may be farther away and may not have the optimal services. In 2003 ambulances were diverted from the closest emergency rooms 501,000 times – an average of once every minute.”¹⁹

Between 1993 and 2003 emergency room visits grew by 26%

The ill and disenfranchised are dumped at emergency room doors for possible admission and treatment by a health care system strapped for sufficient resources. After receiving medical treatment, the same disenfranchised are all too often dumped from a health care system in dire need of resources, into shelters struggling for sufficient resources or alone onto streets with no *resources*.

These *dumpings* are not urban myths. The images, the articles and the sound bites confront us and awaken us to a reality in urgent need of remedy.

Scope of Problem in Los Angeles County

Carol Anne Reyes was dropped off by a taxi in front of the Union Rescue Mission wearing a hospital gown and diaper.



The surveillance camera video – on March 20, 2006 -- showed Carol Anne Reyes shuffle along the sidewalk toward the entrance of the Union Rescue Mission in the Skid Row area of downtown Los Angeles. She had just gotten out of a taxicab, she was sixty-three years old, wore a hospital gown, a diaper, and socks. Ms. Reyes was discharged from Kaiser Permanente’s Bellflower Hospital where she had been hospitalized for three days, put into a taxi, and dropped off in front of the

Union Rescue Mission. Before her hospitalization she had lived primarily in a park in Gardena, California. She was not new to homelessness. She was, however, new to Skid Row – seventeen miles west of Kaiser Permanente in Bellflower and sixteen miles north of her park in Gardena.

¹⁹ Institute of Medicine: Fact Sheet: June 2006. “The Future of Emergency Care: Key Findings and Recommendations”



The CBS documentary '60 Minutes' on May 17, 2007, interviewed Anderson Cooper about the surveillance tape.²⁰ Cooper reported that Ms. Reyes suffered from dementia and that, according to hospital records, was not oriented to time or place. Apparently neither Ms. Reyes nor the Union Rescue Mission expected her arrival on Skid Row. According to Anderson Cooper a staff member noticed her outside the mission and persuaded her to come inside.

On November 16, 2006, Los Angeles City Attorney Rocky Delgadillo – joined by representatives of the Los Angeles Police Department, the American Civil Liberties Union, and the Public Counsel Law Center – announced that he had filed both civil and criminal charges against Kaiser Foundation Hospitals in a case involving the dumping of homeless hospital patient Carol Ann Reyes on Skid Row. “With these criminal and civil filings, I intend to hold Kaiser accountable for violating State law, breaching its commitment to its patients, shirking its obligations under the Hippocratic Oath, and, perhaps most importantly, offending principles of common decency,” said Delgadillo.²¹

If the treatment of Carol Anne Reyes had been an isolated, aberrant ‘glitch’ in an otherwise efficient and effective system, public outrage would certainly have still been appropriate but the over hauling of a flawed system would have been unnecessary. Her situation, however, was not isolated. For several months before Delgadillo’s announcement, Los Angeles city officials had suspected that medical centers and law-enforcement officials from other parts of the county had been dropping off their indigent patients in the Skid Row area.



According to the LAPD, Johnny Williams was one of five patients from L.A. Metropolitan Medical Center who was dumped on Skid Row.

Ina Jaffe of National Public Radio’s ‘All Things Considered’ told her listeners, “Authorities are launching a criminal investigation after police officers in Los Angeles say they videotaped five hospital patients being dumped on Skid Row over the weekend. The incident is being cited as the latest in an ongoing problem of indigent hospital patients being dumped on the streets with no one to care for them.”²²

According to Ms. Jaffe, when the police interviewed the first few ambulance drivers they found out that the drop-offs were not ‘flukes’ but, “... were more like a plan.”

²⁰ CBS News -- 60 Minutes -- “Dumped On Skid Row” -- Anderson Cooper Reports On The Practice Known As “Hospital Dumping” May 17, 2007

²¹ News From the Office of the City Attorney – Thursday, November 16, 2006.

²² All Things Considered, October 24, 2006. – ‘Hospital Dumped Patients on Skid Row, Police Say’ – Ina Jaffe – <http://www.npr.org/templates/story/story.php?storyId=6376588>



By November, 2006, the Los Angeles Police Department believed that several major hospitals had been dumping patients into the Skid Row area for at least a year and a half – Kaiser’s West Los Angeles Hospital, Martin Luther King Jr. /Drew Medical Center, and Los Angeles Metropolitan Medical Center.

The complaint brought to the Superior Court of the State of California, County of Los Angeles, by Carol Ann Reyes charged Kaiser Foundation Hospitals with elder abuse and neglect, breach of fiduciary duty, false imprisonment, negligence, intentional infliction of emotional distress, and violation of the unfair competition law.



Los Angeles Police Chief William Bratton discussed the criminal investigation of homeless patient dumpings by ambulances onto Skid Row. October 24, 2006.

The case sought to “... put an end to this inhumane and illegal practice. Plaintiff is informed and believes that Kaiser has engaged in this conduct with full knowledge that the persons it transports to Skid Row will not continue to heal or recuperate in that setting and that no social service agency on or near Skid Row can provide for the rehabilitative and medical care these persons require.”²³

The action taken by Delgadillo against the Kaiser Foundation was the first criminal prosecution of a medical center.²⁴ Then there was Gabino Olvera. On January 17, 2008, Gabino Olvera, Plaintiff, filed a Complaint for Personal Injuries in the Superior Court of the State of California against CHA Hollywood Medical Center, Empire Transportation, Inc., along with over twenty individuals and demanded a jury trial related to allegations of elder abuse and neglect, breach of fiduciary duty, intentional infliction of emotional distress, and several instances of negligence.²⁵ According to the complaint, on February 8, 2007, Mr. Olvera – a mentally ill, paraplegic, and homeless man -- was discharged from Hollywood Presbyterian Hospital onto a street in the Skid Row area of Los Angeles. The complaint states that Mr. Olvera was transported across town in a van. The driver “... forced him to get out and abandoned him in the gutter of the street without a wheelchair or other means of transportation or movement. Still wearing a soiled hospital gown, with an in-dwelling Foley catheter and catheter bag, and with still-untreated acute medical conditions, Mr. Olvera had no choice but to physically drag himself along the gutter of the street with his belongings in a bag clenched in his teeth.”²⁶

²³ Superior Court of the State of California, County of Los Angeles – Carol Ann Reyes, an individual, vs. Kaiser Foundation Hospitals, a California corporation; Kaiser Foundation Health Plan, Inc., a California corporation; The Permanente Medical Group, a California corporation; and Does 1 through 20, inclusive, Defendants.

²⁴ Senior Journal.com – Senior Citizens Information and News – ‘Hospital Dumping of the Old and Demented Hits Los Angeles Court’ – November 17, 2006.

²⁵ Superior Court of the State of California, County of Los Angeles – Gabino Olvera, Plaintiff, vs. CHA Hollywood Medical Center, a California limited partnership, CHA Health Systems, Inc., a California corporation, Empire Transportation, Inc., a California corporation, Finece Mathis and Does 1 through 20 inclusive, Defendants – Case No. BC383940.

²⁶ Olvera vs. CHA Hollywood Medical Center, etc. – General Allegations, Introduction, Section 1.



The complaint further states that, “Defendants’ treatment of Mr. Olvera is perhaps the most obscene and callous example of the practice commonly referred to as ‘homeless dumping’. All too often, homeless patients in emergency rooms are given cursory examinations and dumped miles away on the streets of ‘Skid Row’ without any means of accessing follow up care.”²⁷

The action taken in such cases shows the beginning of a positive shift towards ending the egregious act of hospital dumpings. On Tuesday, May 15, 2007, the American Civil Liberties Union announced a settlement in the lawsuit of ‘Carol Anne Reyes’ in which Kaiser agreed to provide new policies to end alleged patient dumping and establish model practices for other hospitals to follow.”²⁸

On May 30, 2008, Hollywood Presbyterian Medical center agreed to a settlement in the Olvera case in which the hospital will pay \$1 Million towards discharge planning for homeless patients, as well as be monitored by a former U.S. attorney for five years²⁹. The settlement is a big step for the city of Los Angeles and past efforts to end dumpings. The Medical center will now “adopt new discharge rules and enhance services for homeless patients” and the “\$1 Million will go to non profit groups that aid the indigent and homeless patients³⁰.” Under the settlement rules, the hospital will be monitored on its prevention and compliance by Lourdes Baird, a former U.S. attorney and will require staff, including social workers, nurses and physicians, to assess homeless patients’ cognitive status, and make appropriate recommendations. The hospital and Empire Enterprises, as well as the van company that dumped Olvera, are also paying civil penalties, including a personal trust to care for Mr. Olvera.

The new ordinances, hospital practices and criminal prosecutions are a step in the right direction, but the obscenity of patient dumpings has yet to cease. On March 25th, 2008, Deputy City Attorney Gordon Turner was called to investigate yet another woman dumped directly from care at a local hospital to a shelter in Los Angeles³¹. The woman was dropped off at the doorstep of the New Image Emergency Shelter by an ambulance with two bottles of medication. Hospital representatives continue to argue that the incidence of dumping has concluded, but Turner and the City Council disagree: “On March 20, the council’s Ad Hoc Homeless Committee unanimously passed an ordinance that would make it a misdemeanor for hospitals to dump patients.”³²

²⁷ Olvera vs. CHA Hollywood Medical Center, etc. – General Allegations, Introduction, Section 4.

²⁸ ACLU of Southern California News Release – “ACLU/SC and Public Counsel Settle Lawsuit Over Dumping of Woman on Skid Row: Court to Appoint Monitor to Oversee New Model Policies Intended to End Practice.” – Tuesday, May 15, 2007.

²⁹ Skid Row Dumping Suit Settled. Richard Winton, Los Angeles Times, May 31, 2008.

³⁰ Skid Row Dumping Suit Settled. Richard Winton, Los Angeles Times, May 31, 2008.

³¹ Homeless Dumping Still Happening: Two Years After the Issue Exploded, Council Moves to Criminalize the Practice. Richard Guzman Downtown News March 31, 2008.

³² Homeless Dumping Still Happening: Two Years After the Issue Exploded, Council Moves to Criminalize the Practice. Richard Guzman Downtown News March 31, 2008.



Value of Conducting Discharge Planning

In a 12-1 vote, the Los Angeles City Council voted in May of 2008 to make the dumping of patients a misdemeanor punishable with up to a \$25,000 fine. This measure makes the dumping of patients a crime in Los Angeles, the first ordinance of its nature.³³ The value of conducting discharge planning does not just translate onto the patients but the hospitals as well. Proper discharge planning can prevent patients from becoming homeless and hospitals from dumping patients they wouldn't else wise have a plan for. Once the ordinance becomes law, hospitals will not be able to afford to ignore the need for discharge planning.

At the center of the 'dumping' situation, is a social, legal and medical dilemma. Because of the plights of Ms. Reyes, Mr. Olvera and others we can see that hospital dumping is illegal and inhumane. However, Ms. Reyes and Mr. Olvera were homeless before their original hospital admissions. Their discharges, however egregious, did not cause them to be homeless. This is why discharge planning should commence upon admission into a hospital. The Interagency Council on Homelessness³⁴ (1994) stated that inadequate discharge planning is a significant, contributing factor to homelessness among persons with mental illness and/or substance use disorder. However, others assert that only "a modest" amount of research supports the idea that effective discharge planning can make a difference in preventing homelessness.³⁵ From there, the debate widens exponentially as activists and social scientists point to chronic deficiencies in mental health treatment programs, outpatient medical services, and housing options as contributing elements to post-discharge homelessness. For the purposes of this chapter, the questions orbit around the role of hospitals in preventing homelessness, and more specifically, identification of effective discharge practices in the prevention of homelessness. Currently, discharge planning has been ineffective as hospitals have not yet accepted responsibility for where their patients will go upon completion of treatment. This new ordinance will force hospitals to finally take responsibility, and there is a breadth of research that outlines the best practices for discharge planning from hospitals.

³³ Press Release: Council Member Jan Perry, City Attorney Delgadillo Lead effort to create local ordinance to deter patient dumping. May 14, 2008.

³⁴ see <http://www.usich.gov>

³⁵ Moran, G., R. Semansky, E. Quinn, R. Noftsinger & T. Koenig. 'Evaluability Assessment of Discharge Planning and the Prevention of Homelessness, Final Report' – 2005 – Prepared by WESTAT, Rockville, Maryland.



Discharge Planning Model

Sandwiched in between the hospital discharges of Carol Anne Reyes and Gabino Olvera is Assembly Bill number 2745. Approved and signed by Governor Arnold Schwarzenegger on September 29, 2006, AB2745 addressed the issue of discharge plans for homeless patients and made the violation of its provisions a crime. Passage of the bill amended the California Health and Safety Code's Section 1262 to include the following:³⁶

- No hospital may cause the transfer of homeless patients from one county to another county without prior notification to, and authorization from, the social services agency, health care service provider, or nonprofit social services provider
- A "homeless patient" means an individual who lacks a fixed and regular nighttime residence
- Each hospital shall have a written discharge planning policy and process
- The policy requires that appropriate arrangements for post hospital care are made prior to discharge
- Patients shall be informed orally or in writing of post discharge needs
- A transfer summary shall accompany the patient upon transfer to any other health care facility. The patient will be given a copy of the transfer
- The patient will receive information about medications
- The hospital shall provide every patient in need of long-term care at the time of discharge with contact information for at least one public or nonprofit agency or organization dedicated to providing information or referral services relating to community-based long-term care options
- Each hospital shall provide each patient, upon admission or as soon thereafter as reasonably practical, written information regarding the patient's right to the following: (1) to be informed of continuing health care requirements following discharge from the hospital. (2) To be informed that, if the patient so authorizes, that a friend or family member may be provided information about the patient's continuing health care requirements following discharge from the hospital. (3) Participate actively in decisions regarding medical care. To the extent permitted by law, participation shall include the right to refuse treatment.

The disconnect taking place between hospitals and aftercare providers is one that is common amongst different populations dealing with discharge planning. This disconnect between providers must be addressed in order to properly plan for a patient's release, especially a currently or previously homeless patient. Fluid communication between service providers and the hospital can prevent dumpings from taking place.

³⁶ California Health and Safety Code, Section 1262.4 – Section 1262.6



Who Should Be Involved In Discharge Planning?

Hospital discharge planning is a complex, ambiguous and often territorial activity. Approaches to discharge vary considerably from hospital to hospital. In some hospitals, discharge planning is the responsibility of the nursing staff. In others it is the responsibility of the social work staff. Some hospitals create quantifiable, standardized assessment tools while others utilize a less formal approach to intake screening. Pre-admission health care and post-discharge healthcare seem to be essential components of effective discharge planning in some communities. As the number of the nation's homeless increases, discharge processes of hospitals receive greater scrutiny. The primary concern seems to be the impact the discharge plan and the actual discharge may have on homelessness.

Because discharge planning is considered an essential component of hospitalization, a review of current literature dealing with hospital discharge planning in general and discharge planning for the homeless or for those at risk of becoming homeless focused on synthesizing the discharge practices (both actual and theoretical) of a number of hospitals.

Of the screening procedures reviewed in the literature, most assigned the screening responsibility to either a hospital social worker or nurse. Researchers concluded that although social workers and nurses tend to possess different skill sets, there is no empirical evidence to suggest that one is more qualified than the other and no significant difference in their perceived effectiveness as discharge planners.³⁷ As expected, social workers tended to be more inclusive of psychosocial factors outside of the patient's health status while nurses cited their expertise in medicine, medical diagnosis and treatment as key factors in their effectiveness as discharge planners.³⁸ Nurse discharge planners focus on the individual patient whereas social work discharge planners focus on families and systems.³⁹ Based on these findings, it may be that *who* completes the screening is less important than *how* the information is collected with regard to best practices.

³⁷ Holliman, D., S. F. Dziegielewski & R. Teare. "Differences and Similarities Between Social Work and Nurse Discharge Planners". Health and Social Work. August, 2003. Volume 28. Issue 3.

³⁸ Holliman, et. al.

³⁹ Rehr, H. "Discharge Planning: An Ongoing Function of Quality Care." Quality Review Bulletin, 12 (2), 47-50. 1986



Elements of Successful Discharge Planning

Although discharge procedures are required and monitored by the Joint Commission on Accreditation of Health Care Organizations (JCAHO), there is a rather wide variance in how hospitals provide and design these services. While little dispute seems to exist that discharge planning optimally begins at admission, the type of information captured, who captures it and what is done with the information seems less standardized. In the absence of a specific discharge planning screening tools, most hospital discharge planners, whether social worker or nurse, draw their discharge information from progress notes in the patient's chart or from nursing care plans.⁴⁰ The question is, can a comprehensive psychosocial picture emerge from these sources?

Fairchild and colleagues (1998)⁴¹ suggest the need for standardized screening instruments formulated around prediction rules. While Fairchild's proposal focuses on post discharge medical needs, the implementation of such an instrument could effectively identify other discharge needs such as homelessness or incipient homelessness.

It is more often the case that hospital screening procedures involve less comprehensive tools. Much of the literature on discharge models identifies screening tools as essential, but provides only general descriptions of the information captured. In their analysis of effective discharge planning in preventing homelessness, Backer et al. (2007)⁴² suggest that a symptom checklist completed at the time of admission can capture essential discharge factors. Identification of factors such as anticipated length of stay, history of mental illness, substance abuse, and history and status of homelessness help discharge planners anticipate and plan for discharge dilemmas.

Elements of a successful discharge planning protocol should include the following:

1. Discharge planning should begin at admission.
2. Utilize a specific discharge planning screening tool so that information is not solely drawn from progress notes.
3. Formulate standardized screening tools around prediction rules—a symptom checklist or some other format can be utilized.

⁴⁰ Iglehart, A. P. "Discharge Planning: Professional Perspective Versus Organizational Effects. Health & Social Work. November 90, Volume 15, Issue 4. 1990.

⁴¹ Fairchild, David. G., M.D., Mairead L. Hickey, RN, PhD., E. Francis Cook, ScD., Rita M. McCarthy, Rn, MS, Laura P. Rossi, RN, MS, Samantha C. Timmons, BA & Carol M. Mangione, M.D. "A Prediction Rule for the Use of Post-discharge Medical Services." Journal of General Internal Medicine. Volume 13, February, 1998.

⁴² Backer, T. E., E. Howard & G. Morgan. "The Role of Effective Discharge Planning In Preventing Homelessness". Journal of Primary Prevention. 28:229-243. 2007.



4. Select most appropriate clients for discharge planning.

Examples of Model Programs

Kaiser Model On Tuesday, May 15, 2007, lawyers from the American Civil Liberties Union of Southern California and Public Counsel joined by Los Angeles City Attorney Rocky Delgadillo announced a settlement of the criminal charges filed against Kaiser Permanente by Carol Ann Reyes. As part of that settlement, Kaiser agreed to adopt new discharge protocols for homeless patients and training procedures for hospital staff members who work with the homeless.⁴³

On that same day, Kaiser Permanente announced its response to the health care needs of the homeless in Southern California.⁴⁴ Benjamin Chu, M.D., MPH, president, Kaiser Permanente Southern California region, thanked City Attorney Rocky Delgadillo and his team for their efforts on behalf of the homeless and stated that, while the 'unfortunate incident' of Carol Ann Reyes was isolated, Kaiser had taken very strong steps to guarantee no future such incidents. Kaiser agreed to contribute \$500,000.00 toward the creation of a database to link shelter providers and hospitals, the establishment of a free legal clinic in the Skid Row area, and the expansion of recuperative beds in Los Angeles County.

Kaiser stated that its homeless care efforts in Southern California would focus on the following:

- Care coordination and case management to link homeless patients to community resources such as mental health care, housing, and drug treatment
- Step down beds (recuperative care) for the homeless who still require hospital care but at a lower level
- Training for social workers and discharge planners related to the special needs of the homeless
- Investments in agencies and providers to expand access to care

Dr. Chu went on to say that Kaiser, as part of the agreement, developed specific discharge protocol to ensure that shelters were always called in advance and that transportation was always provided in a van with an attendant.

⁴³ ACLU of Southern California Press Release dated Tuesday, May 15, 2007 (<http://www.aclu-sc.org/News/Releases/2007/102412/>)

⁴⁴ KP News Center, May 15, 2007. (<http://xnet.kp.org/newscenter/>)



The Hospital Association of Southern California has made the Kaiser Foundation Hospitals Regional Protocol on Homeless Discharge Planning available to the public.⁴⁵

- Identification at the time of admission of homeless patients
- Documentation of belongings The policy further states that adequate clothing will be provided at the time of discharge if needed
- Mental status assessment to determine the patient's ability to understand treatment options, necessary follow up, and discharge plans. The policy further states that discharge would be delayed until the resolution of any concerns about the patient's ability to provide self care.
- The policy states that discharge planning begins at the time of admission
- The policy identifies staff involved in the discharge process as the treating physician, a social worker, a member of the nursing staff and – if needed – staff members able to provide vocational or financial assistance and other supportive services
- Patient participation was an essential part of the discharge process
- Patients would be referred to appropriate shelters and provided appropriate transportation
- The policy also states Kaiser's commitment to creating relationships within the community to maximize resource availability
- The policy states that the Executive Director of each Kaiser Foundation Hospital will be held responsible for compliance with the policy
- And finally the policy states that Kaiser will provide training for all staff involved in discharge planning of homeless patients

While this protocol addresses many important aspects of discharge planning such as beds for lower levels of care, identification of involved staff, and mandated training it does continue to utilize current community resources and those current resources are primarily shelters.

*Massachusetts Housing and Shelter Alliance (MHSA)*⁴⁶ The Massachusetts Housing and Shelter Alliance (MHSA), established by 80 non-profit homeless agencies, seek to create a coordinated strategy to end homelessness. MHSA is committed to ending homelessness by decreasing the dependence of homeless people on the government and creating options for homeless people to exercise their self determination. Through strategic partnerships formed with government, private philanthropy, service providers, homeless individuals, and business, MHSA works to ensure that homelessness does not become a permanent part of the social landscape. As a function of this objective, MHSA has explored the ability to prevent homelessness through appropriate hospital discharge planning.

⁴⁵ <http://www.hasc.org/ps.index.cfm?ID=2198>

⁴⁶ See www.mhsa.net/



As MHSA tracked homeless data, they discovered a couple disturbing trends. First, a considerable number of the homeless occupying area shelters had been discharged to the shelter from institutions including hospitals. Second, although the system of homeless services was building an effective continuum of care, mainstream systems, like hospitals, continued to act “dysfunctionally.” Managed care systems, including network hospitals continued to discharge homeless patients to emergency shelters.

MHSA set out to make policy change with regard to hospital discharge planning and develop resources. Discharge planning policy change essentially amounted to a specific policy mandate: zero tolerance for discharge to homelessness. Hospital discharge planners were quick to point out, however, that even though they agreed in principle to the zero tolerance policy, in practice, it was unrealistic because housing resources in the community for the homeless were insufficient. Emergency housing shelters were often the only available alternative other than discharge to “the street.” Not only was there a need for housing resources, but also an effective information system to provide updated data regarding vacancies and availability of services.

MHSA decided to use electronic technology to improve discharge planning for the homeless. They answered the call with Triple 8: The Road Home, an interactive multimedia information tool. Triple 8 provides current vacancy information on next step resources and can be faxed or emailed to discharge planners who can also simply go to the triple 8 website. A hospital discharge planner can request information about available services by region of state. According to MHSA, “within a few moments”, the discharge planner will receive a faxed or emailed report with a description of the services, eligibility requirements, and contact information offered by programs that match the query.

Implications Discharge planners need multimedia tool such as MHSA’s Triple 8 in order to match and link patient discharge need to community resource. To make a system such as this effective, however, requires the involvement of all participating providers to update availability of resources on a daily, perhaps even hourly basis. To make this work, all providers, including the hospital must commit the necessary time, money, and personnel. Appropriate and timely discharge of homeless individuals outweighs the cost in both the direct benefit to the homeless patient as well as reducing unnecessary length of stays, reducing re-admission rates due to insufficient post-discharge care, and decreasing time needed by discharge planner locating resources.

Medical Respite Care Model, Sacramento Even basic needs for post-discharged homeless individuals can be difficult for hospital discharge planners to secure. Adding physical recovery and recuperation to the list of needs creates an almost impossible task. Alternatively, keeping the homeless patient in the hospital during the recuperative stage leads to misuse of acute care services and results in financial burdens on the hospitals. In Sacramento, a collaborative made up of community organizations, hospital systems, and the county government pooled their efforts to develop, fund and manage a respite care shelter for homeless patients discharged from hospitals located in Sacramento County. The project’s goal was to improve quality of care and increase the probability of recovery for homeless patients.



Other benefits include freeing up hospital beds for those in need of acute care and reducing readmissions and emergency room visits.

The benefits of medical respite care shelters in terms of reduced utilization of emergency department, reduced inpatient days, and reduced clinic visits was studied by researchers in Chicago and Boston. The results affirmed that medical respite programs can provide an effective place for homeless patients to recover, while reducing hospital re-admission due to insufficient recovery.⁴⁷

The Interim Care Council, made up of representatives from the hospital systems (four local hospitals), the Salvation Army, Sacramento County, and the Mexican American Alcoholism Program (MAAP, Inc.), developed the program as a true collaborative effort. Each of the four hospitals contributed \$50,000 while the County of Sacramento contributed \$118,000. MAAP, Inc. agreed to provide part-time case management and nursing services to the shelter as well as providing overall administrative responsibility. The medical respite care program was physically located within a pre-existing Salvation Army shelter. The 18-bed respite care shelter consists of 6 rooms (one room for women, five rooms for men), each with 3 hospital beds, sink, and toilet area. Hallways and rooms are all wheel-chair accessible and provide storage for medications and wound care supplies. This part of the shelter is open throughout the day and three meals per day are provided. The Salvation Army does not provide medical care. Instead, case managers from MAAP, Inc. help link the recuperating homeless individual with local medical services such as primary care physicians and public health clinics.

Prior to referring to the medical respite care shelter, the hospital discharge planner must first verify that the patient meets the shelter criteria which includes the medical need for recuperative care, patient must be ambulatory, must be “clean and sober”, etc. Based on patient’s condition, the discharge planner estimates the patient’s length of stay in the shelter. If approved by the shelter nurse after reviewing the referral paperwork, the patient’s physician is notified, discharge orders are given, and the patient is transported to the shelter.

Does it work? The Interim Care Council reported that the program served 121 homeless patients during its first year, with an average daily census of 13. Data on costs have not yet been published, but Interim Care Council members are confident that it is, indeed, paying for itself in the reduction of hospital stays, subsequent emergency department visits, and re-admission.⁴⁸

⁴⁷ Buchanan, David. MD, Bruce Doblin, MD, MPH & Theophilus Sai, MD, “The Effects of Respite Care for Homeless Patients: A Cohort Study.” *American Journal of Public Health*. July 2006, Vol. 96, No. 7

⁴⁸ California Healthcare Foundation. “No Place To Go: Addressing the Challenge of Homeless Patients in Sacramento.” *Issue Brief*. July. 2006.



Most, if not all would agree that medical respite care centers for the recuperating homeless individual represent an appropriate and effective alternative to costly extended hospital stays or worse, the medically compromised homeless individuals discharged to a shelter. Moreover, most would also agree that healthcare institutions will need some coaxing, maybe a lot, to consider doling out their share of limited finances to support the centers. This may come down to simple case of cost comparisons. Healthcare institutions may discover that they are already spending far more by doing nothing as they continue to incur non-reimbursable costs of services to homeless individuals.

*Common Ground and Bellevue Hospital*⁴⁹ Founded by Rosanne Haggerty in 1990, Common Ground is a pioneer in the development of supportive housing and other research-based practices that end homelessness. Common Ground's network of well designed, affordable apartments -- linked to the services people need to maintain their housing, restore their health, and regain their economic independence -- has enabled more than 4,000 individuals to overcome homelessness. Common Ground has developed and operates a range of housing facilities serving formerly homeless and low income households located in New York City, the Hudson Valley and Connecticut. In addition, Common Ground operates programs designed to prevent homelessness among vulnerable individuals and groups and to assist long-term homeless adults in accessing housing.

In a collaborative effort with Bellevue Hospital in New York City, Common Ground developed a homeless discharge planning procedure with the objective of effectively linking homeless patients to housing at time of discharge. Common Ground recognized that not only do homeless individuals use hospital emergency services for their primary (and only) medical care, but that there is a subset of homeless who are frequent users of these services. Common Ground developed an initiative to essentially "prescribe" housing to a homeless individual as a medical intervention. Upon their admission, homeless individuals with complex needs who frequently use hospital services are identified and are offered immediate access to supportive housing. Common Ground initially funded this pilot program with funds from private foundations (one third) and housing subsidy funds from the City of New York (one third) and from Common Ground earned income from other services (one third). The annual operating budget is \$200,000.

Common Ground assumes that once homeless individuals are housed, their health will improve and, subsequently, will require fewer inpatient days. From a financial perspective, housing and homecare (preventative medical care) cost much less than hospitalization, saving the publicly funded healthcare system substantially. Studies in California and Connecticut showed a 50% reduction in Medicaid costs when similar services for homeless individuals were implemented.

⁴⁹ See www.commonground.org/



If they are able to show a cost savings to Medicaid and other public payers of healthcare services, then Common Ground will propose that Medicaid should pay for housing services targeting those homeless with chronic health issues and who are frequent users of inpatient services.

The glaring dilemma with prescribing housing for homeless patients is that it only works when one has the housing resources to prescribe. Nevertheless, what is important and worthwhile about this model is that it demonstrates how healthcare institutions can be part of the intervention on homelessness. In theory, homelessness can be abolished, one individual at a time, as these homeless individuals interact with various community services, such as healthcare institutions. This requires a commitment from all institutions to prevent the perpetuation of homelessness, which is exactly what happens when an individual is discharged to an emergency shelter or the streets.

Recommendations for Providers

For almost a decade, the State of California responded to the needs of the homeless mentally ill with its landmark program AB2034. In one of many instances of funding cutbacks, all AB2034 programs in the state were eliminated in the summer of 2007 and housing for the homeless mentally ill in California became even more difficult. Homelessness, of course, is not the sole domain of the mentally ill. The end of California's program, however, does illustrate the plight of providing resources for the homeless and of marshalling resources to end homelessness.

A recent report from SAMHSA (Substance Abuse & Mental Health Services Administration)⁵⁰ tells us that over a five year period 3% of the population of this country will experience at least one night of homelessness. Should that seemingly small percentage happen to become homeless at the same time, eight million people will be looking for a safe place to sleep. As the number of homeless grows daily so, too, do healthcare demands.

The EMTALA legislation mandates that hospital emergency rooms provide treatment regardless of ability to pay. Indications are, however, that EMTALA enforcement is neither uniform nor consistent. A report by the 'Public Citizen' indicated that by April 2001 only 85 (17%) of the 527 hospitals found to be in violation of EMTALA in 1986 has actually been fined for those violations.⁵¹ In many instances, therefore, the homeless do not even enter the hospital.

⁵⁰ See <http://www.samhsa.gov>

⁵¹ Common Dreams: Progressive Newswire (<http://www.commondreams.org/news> -- "Hospitals in Nearly Every State Violate Federal Patient Dumping Law, Study Shows" – Booth Gunter (2001)



However, once a homeless patient is admitted into a hospital, legislation – at least in California – mandates appropriate discharge processes. While the law does not mandate that housing be provided upon discharge, it does place a greater level of discharge responsibility upon the hospital. Brian Johnston, chief of emergency services at White Memorial Hospital, recently editorialized that ‘dumping’ is a symptom of a greater systemic problem and that punishing hospitals does not address the root causes of homelessness.⁵²

Building the “Perfect” Model While the one, perfect model for hospital discharging of homeless patients does not yet exist, effective models do exist. And effective discharge of homeless patients – as part of the bigger homeless dilemma in this country – can play an essential role in the reduction and eventual elimination of homelessness. Sherrie Dulworth believes that hospital case management must be elevated on the hierarchy of health care professionals because ‘critical mass’ has been reached.⁵³ She speaks of the need for improving quantifiable quality processes or outcomes and evidence based guidelines as essential to effective hospital discharge planning. To improve hospital discharge outcomes with the homeless, best practices with the greatest impact on outcomes can be grouped into two domains:

- (1) Discharge Protocols – Discharge planners must be provided with a list of discharge principles such as those implemented by Kaiser Foundation.
- (2) Development of Community Collaborative – The creation of essential community collaborative requires a re-conceptualization of discharge planning to expand the responsibility of hospitals beyond institutional doors.

Barriers Improving discharge planning protocols, without addressing resource needs in the community, runs the risk of missing an opportunity to intervene in the homeless cycle. If hospitalization can be seen as an access point at which a homeless individual contacts a *resource conduit*, the issue can assume a greater intensity and shift from ‘managing’ the homeless to ‘ending’ homelessness.

Hospitals now find themselves in a crucial position that requires a rethinking of community responsibility. Homelessness will no longer be seen as a territorial issue. Hospitals, then, will have little choice but to become part of the continuum of care in the provision of services for homeless individuals. This continuum will of necessity include entire communities and states and, yes, even the entire country working together toward the elimination of a national disgrace – homelessness. In order for that to happen, case managers and discharge planners must be viewed as essential. Networks must be created and maintained. And, as Kaiser pledged, resources must be directed toward community awareness and involvement in order to build the bridge from the homeless to the housed.

⁵² Johnston, Brian. Los Angeles Times. – Opinion – ‘Dumping is just a symptom.’ February 28, 2007.

⁵³ Dulworth, Sherrie, RN, CPHRM. “Case Management and Quality: Have We Reached a Tipping Point?” The Case Manager. Volume 17. Issue 5.



Chapter Three: Discharge Planning for Foster Care

Youth who exit the States' child welfare care are impacted by the instability and fractured discharge planning of the foster care system. It is evident that emancipating from foster care is a contributing factor for youth who become homeless. Nationwide, twenty five percent of former foster youth reported being homeless before their fourth year of emancipation⁵⁴. The inadequate discharge of youth from the child welfare is not unique to this population. On the contrary, youth aging out of foster care share similar risks of becoming homeless as adults who are released from varying systems of care⁵⁵. However, emancipating foster youth face unique barriers and risk factors that can hinder their transition to lead self sufficient lives.

Examples of roadblocks that these young adults face include lack of family, emotional support and financial stability that assures success in living independent lives⁵⁶. A review of literature clearly indicates that a well developed discharge or transition plan would prevent homelessness amongst youth who exit the foster care system. The child welfare system must have in place empirically based discharge methods that will reduce homelessness amongst its children who age out.

The following sections will outline the scope of the problem, the value of conducting discharge planning as well as the necessary elements of successful planning, model programs and who should be involved. A discharge plan template, a plan checklist and a logic model are included in appendices E, F and G.

⁵⁴ Cook, R., (1991). A national evaluation of title IV-E foster care independent living programs for youth, phase 2. Final Report, Volume1. Rockville, MD: Westat Inc.

⁵⁵ Moran, G., Semansky, R., Quinn, E., Noftsinger, R., & Koenig, T. (2005). *Evaluability assesment of discharge planning and the prevention of homelessness. Final Report*. Rockville, Maryland: WESTAT.

⁵⁶ Collins, E. (2001). Transition to adulthood for vulnurable youths: A review of research and implications for policy. *Social Service Review* .



Scope of Problem & Data Elements

National The AFACRS⁵⁷ provides the most comprehensive data on foster youth. The report finds that there are approximately 513,000 children and adolescents in out-of-home care in the United States and about 105,000 of these youth are ages 16-21 years. Of this, roughly 32,000 have case plans with emancipation as the treatment plan. The report further states that 9 percent of all of the young people in foster care (about 24,000) emancipated from the system in 2005.

California In California the figures are just as staggering. CA has the largest foster care population in the United States with 97,261 children as of September 30, 2003. In July 2002, there were 40,059 youth between 11 to 18 years of age in its child welfare system. This age group represents 46 percent of all children in California to be in supervised foster care. Foster youth between 16 and 18 make up 29 percent (11,600) of this age group⁵⁸. The California Dept. of Social Services (CDSS)⁵⁹, approximates that 4,355 foster youth leave the California foster care system each year, with the majority of about 70 percent leaving care at age 18.

Challenge: Cycle of Services Foster youth face many challenges upon emancipation from the State's care that can impact their transition to self sufficient lives. The lack of assistance in securing a support network, financial, educational, vocational, health, emotional, food and housing services tends to lead former foster youth to reenter the system of care as adults⁶⁰. In a study of 10,228 youth who emancipated foster care, approximately 65 percent entered the foster care system between ages 11 and 19⁶¹. The Casey Family Programs also found that those adolescents who emancipate from out-of-home care systems will eventually receive services as adults either through the criminal justice system, the welfare system, or as residents of homeless shelters⁶².

⁵⁷ Adoption and Foster Care Analysis and Reporting System (AFCARS). (2006). *The AFCARS Report*. Washington, D.C.: U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. http://www.acf.hhs.gov/programs/cb/stats_research/afcars/tar/report13.htm

⁵⁸ U.S. Department of Health and Human Services (U.S. DHHS) (2003). <http://www.hhs.gov/>.

⁵⁹ California Department of Social Services (CDSS). (2002). *Report on the Survey of the Housing Needs of Emancipated Foster/Probation Youth*. Independent Living Program Policy Unit, Child and Youth Permanency Branch.

⁶⁰ Child Welfare League of America. (n.d). *Ensuring safe, stable, and affordable housing for young people aging out of foster care*. National Foster Youth Advisory Council. <http://www.cwla.org/programs/housing/housingpubspage.htm>

⁶¹ Needell, B., Cuccaro-Alamin, S., Brookhart, A., Jackman, W., and Shlonsky, A. (2002). Youth emancipating from foster care in California: Findings using linked administrative data. Berkeley, CA: Center for Social Services Research.

⁶² Casey Family Programs (2000). http://www.casey.org/cnc/fostercare_statistics.html



Foster youth experience significant obstacles in making the transition from the foster care system to independent living⁶³. The following statistics from this study illustrate the cycle of services that former foster youth become a part of:

- Approximately 1 out of 4 receives TANF/AFDC within six years of leaving the foster care system.
- 1 out of 10 receives Medi-Cal for a disability within six years after leaving care.
- A high rate receives mental health services prior to emancipation.
- 4 percent entered the California State Prison System within 7 years after leaving care.
- There are significantly low rates of high school graduation/proficiency, community college attendance, and graduation from 4-year colleges.
- 2 of 3 females have at least one birth within five years after leaving care, and 1 in 5 gave birth within one year after leaving care.

Challenge: Housing and Homelessness There is a considerable number of youth who are streamlined from child welfare systems into homelessness⁶⁴. Specifically, former foster youth are disproportionately represented within the homeless population. It is estimated that every year between 20,000 and 25,000 youth age out of the foster care system and enter into society with limited resources and various challenges⁶⁵. With such high figures, it is unsurprising that one in four former foster youth are homeless at least one night with in four years of exiting the system⁶⁶.

One of the most important adjustments youth will make in the transition to independent living and self-sufficiency is taking on the responsibility for housing⁶⁷. Studies show that temporary or permanent homelessness often results after youth emancipate from foster care. A study conducted by Chapin Hall Center for Children through the University of Chicago followed approximately 750 youth two years after leaving foster care from Illinois, Iowa and Wisconsin. Of those youth, one percent were homeless at the time of the interview and 14 percent reported being homeless at least once since leaving foster care⁶⁸.

⁶³ United States General Accounting Office (GAO) (1999). *Foster Care: Challenges in Helping Youths Live Independently*. Committee on Ways and Means. Washington D.C.

⁶⁴ National Alliance to End Homelessness (NAEH). (2006). *Fundamental issues to prevent and end youth homelessness*. Washington D.C.

⁶⁵ Allen, M., Nixon, R., (2000). The Foster Care Independence Act and the John H. Chafee Foster Care Independence Program: New Catalysts for Reform for Young People Aging Out of Foster Care. *Journal of Poverty and Policy*.

⁶⁶ Cook, R., (1991)

⁶⁷ Sheehy, A. M., E. Oldham, et al. (2000). *Promising Practices: Supporting Transition of Youth Served by the Foster Care System*. Portland, ME, National Child Welfare Resource Center for Organizational Improvement.

⁶⁸ Courtney, M.E., Dworsky, A., Ruth, G., Keller, T., Havlicek, J., and Bost, N. (2005). Midwest evaluation of the adult functioning of former foster youth: Outcomes at age 19. Chicago, IL: Chapin Hall Center for Children, University of Chicago.



Another study found that 22 percent of former foster youth who were in care in Oregon and Washington reported being homeless for one day or more after the age of 18⁶⁹. In the one year between 2000 and 2001 approximately 65 percent of the youth emancipating from California's foster care system needed affordable housing. In addition, only thirty percent of these youth were linked to the Temporary Assistance for Needy Families (TANF) program after leaving care⁷⁰.

Challenge: LGBTQ Foster Youth Lesbian, gay, bisexual, trans-gendered, and queer/questioning (LGBTQ) youth aging out of foster care are often overlooked in child welfare services⁷¹. They face a series of added challenges because of discrimination, harassment and abuse based on homophobia, misinformation, lack of information, and prejudice against their sexual orientation, perceived orientation, or their lack of conformity to gender stereotypes⁷². A recent report found that 15 percent of 321 former foster youth reported being LGBTQ⁷³ and in another survey of homeless former foster youth, thirty-four percent reported being LGBTQ⁷⁴. This sub category of foster care youth have fewer housing options after exiting care than heterosexual youth as a result of not feeling supported by their family of origin or friends regarding their sexual orientation, or not comfortable with 'coming out' as gay, lesbian, or bisexual⁷⁵.

By not receiving emotional and social support around their sexual orientation, or by being stigmatized or victimized, these youth might experience increased mental health and substance use issues. Additionally, these issues could affect their transition into adulthood, as well as their ability to obtain and retain employment and housing⁷⁶. Although the legislature passed the California Foster Care Nondiscrimination Act which ensures fair and equal access to services and prevents discrimination and harassment, there are no formal instruments used to identify youth who are LGBTQ in the State of California. Therefore, it has become a barrier to the availability of evidenced based interventions specifically targeting emancipating foster care youth who identify as LGBTQ.

69 Courtney, M.E., Dworsky, A., Ruth, G., Keller, T., Havlicek, J., and Bost, N. (2005). Midwest evaluation of the adult functioning of former foster youth: Outcomes at age 19. Chicago, IL: Chapin Hall Center for Children, University of Chicago.

70 Needell et al., 2002

71 Bay Area Social Services Consortium. (2006). Emancipating From Foster Care in the Bay Area: What Types of Programs and Services are Available for Youth Aging Out of the Foster Care System? Policy Monograph, Center for Social Services Research, School of Social Welfare, University of California at Berkeley.

72 Richardson, S., Early, B. and Rivera, K. (2005). Creating a group home for LGBTQ youth in out-of-home placement. Masters thesis. San Francisco: SFSU, School of Social Work.

73 Courtney et al. (2005)

74 Lenz-Rashid, S. (2006). Employment Experiences of Homeless Young Adults: Are They Different for Youth With a History of Foster Care? Children and Youth Services Review.

75 Remafedi, G., Resnick, M., Blum, R., and Harris, L. (1992). Demography of sexual orientation in adolescents. Pediatrics, 89, 2, 714-721.

76 Lenz-Rahid, 2006



Scope of Problem in Los Angeles County

The Chief Executive Office, Service Integration Branch (CEO, SIB) of Los Angeles County released a comprehensive Transition Age Youth report in 2007. The report found that in 2006, Los Angeles County served total caseload of 58,572 children in foster care. About 42% of these youth were adolescents to young adults. The numbers are just as staggering when taken at a point-in-time. In December 31, 2006, the caseload count for LA County foster youth 11-22 years old was 17,480. About 60% of these youth were placed in Permanent Placement. When children are unable to return home or have a permanent home they are placed in foster care for longer periods of time, most often until they age out of care. The majority of LA County foster children are Hispanic and African American (44 percent and 39 percent respectively). The largest county regions with foster youth are Service Planning Area (SPA) 6 with 23 percent and SPA 3 with 17 percent (2007). A more recent release by the LA County Department of Children and Family Services (DCFS) showed that 2,629 youth exited foster care for the calendar year 2007⁷⁷.

In Los Angeles County, the number of homeless youth is startling. In 2007, the point-in-time homeless count by the Los Angeles Homeless Service Authority (LAHSA) found that there were 5,264 homeless youth 18-24 years of age in Los Angeles County. The 2007 annual projection of homeless youth living in LA County was calculated at 10,875. About half of homeless youth live in SPA 3 and 4. The homeless youth population is primarily comprised of 46 percent African American and 30 Hispanic; a resemblance in the percentages of foster youth in LA County. There is currently no data tool available to track the homeless population who has aged out of foster care⁷⁸. However, Children's Hospital Los Angeles (CHLA) surveyed several hundred homeless youth in LA County and found that almost 50 percent had some involvement with DCFS or Child Protective Services, including foster home placement. They also found that 60 percent of the homeless youth are male, and that 35 percent are Gay, Lesbian, or Bi-sexual⁷⁹.

Children's Hospital
Los Angeles found that almost 50 percent of surveyed homeless youth had some involvement with DCFS or Child Protective Services.

77 Department of Children and Family Services. (2007). Number of DCFS/Probation Youth that Exited Foster Care for Calendar Year 2007. DCFS- The Site

78 Los Angeles Homeless Services Authority (LAHSA). (2007). 2007 Greater Los Angeles Homeless Count. <http://www.lahsa.org/2007homelesscountreport.asp>

79 Desai, M. (2008). Community Needs Assessment Survey With Runaway & Homeless Youth. Children's Hospital Los Angeles. Unpublished data Updated 3/05/08.



Value of Conducting Discharge Planning

Any adolescent's transition into adulthood is faced with biological, environmental, emotional, and psychological instability. A young person emancipating from foster care has additional challenges to overcome that can make all the difference for leading self sufficient lives. Aging out of foster care with a lack of resources, skills, and no familial support most often corners these young people into homelessness, correctional facilities, substance abuse, and dependency on social services⁸⁰. Youth leaving foster care need to have in place a discharge plan that proves to be effective in assisting their transition to safe and self sufficient lives. This planning process serves the youth best when it begins at an early age and continues through the youth's placement. The literature states that the benefits of conducting discharge planning for youth exiting the foster care systems are⁸¹:

- To reduce homelessness and obtain stable housing
- To increase access to social services such as mental health and substance abuse treatment
- To secure food and housing
- To maintain a positive and reliable social network
- To participate in education or vocational training
- To acquire and manage financial resources

Planning for the discharge of foster youth is not an easy feat and the above mentioned obstacles make the challenge incredibly complex. Effective discharge planning is however essential and can positively impact the one in four homeless foster youth ratio.

⁸⁰ Resnick, et. al., 2007; NAEH, 2006

⁸¹ Moran, G., et. al, 2005



Discharge Planning Model

The best discharge practices involve providing youth with supportive services, independence and autonomy, and by connecting them with adults that provide emotional support and guidance. Assisting in providing permanent housing and economic stability is also a successful approach to teaching youth how to lead self sufficient lives. The youth's involvement in securing housing within their community, and gaining incremental independence by taking over the rental lease and responsibility for the full payment of their housing has prevented youth from becoming homeless, and dependents of welfare services.

Many best practice transitional programs include establishing a reserve fund that would yield enough money for a youth to use toward educational, vocational, or housing needs. The most successful programs matched a youth's earnings as long as the youth met certain educational or vocational requirements. The best practices demonstrated the active involvement of youth at all levels of service delivery, and an effective collaboration between community, governmental, and private systems. One can take a look at these programs' principles to help develop a discharge plan that considers and favors these services.

Across the literature it is suggested that cross-system collaborations are essential in assuring these young adults adequately acquire resources that will assist in their transition to adulthood. In addition, research also suggests having a permanent supportive relationship and feeling connected to an adult is very important to an emancipating foster youth's short and long-term well-being⁸². While recognizing the importance of establishing and sustaining relational permanence in the lives of these youth, service providers challenge the very notion of "independent living" and move toward more interdependent and interrelated notions of healthy adulthood⁸³. When developing and implementing a discharge plan model for this population, one must consider the circumstances preventing foster youth from forming and keeping close relationships. For example, foster youth experience a cycling in and out of foster homes, failed reunification efforts, and undergo multiple caseworkers. "Their foster care experiences, while effectively teaching them how to begin new relationships, did little to provide experiential opportunities to develop relational skills for sustaining or repairing relationships"⁸⁴. Therefore, a discharge model that is sensitive to this construct would benefit a youth's transition to self sufficiency.

⁸² Beam, M. R., Chen, C., & Greenberger, E. (2002). The nature of adolescents' relationships with "very important" non-parental adults. *American Journal of Community Psychology*, 30(2), 305–325

⁸³ Propp, J., Ortega, D. M., & NewHeart, F. (2003). Independence or interdependence: Rethinking the transition from "ward of the court" to adulthood. *Families in Society: The Journal of Contemporary Human Services*, 82(2), 259–266

⁸⁴ Samuels, G.M., (2008). *A Reason, a Season, or a Lifetime: Relational Permanence Among Young Adults with Foster Care Backgrounds*. Chicago: Chapin Hall Center for Children at the University of Chicago.



When considering the many challenges that transitioning foster youth face, and the deficiencies of the foster care system one should be careful that a discharge plan does not unintentionally place a focus on the shortfalls of the youth. Given the vast amount of challenges that youth face, emancipating foster youth nonetheless possess many strengths necessary to succeed in life. A model discharge framework developed by the Casey Family Foundation recognizes successful transition planning as being focused on resiliency, or identifying the factors contributing to a young adults' ability to overcome life challenges. The *It's My Life* framework identifies resilient youth as possessing self-esteem and confidence; a belief in their ability to affect their own lives; and problem solving abilities⁸⁵.

It is without question the transition from foster care emancipation to self sufficiency is a challenging one. In addition to the setbacks out-of-home care places on children, larger societal factors also contribute to their increased risk of homelessness. A well developed discharge plan may be limited in achieving successful housing outcomes due to the overwhelming shortage of community resources, such as low-income housing, employment, mental health services, substance abuse treatment, affordable child care, etc. The discharge planning process will not solely end homelessness, but only serve as a method that needs to be substantiated with the availability of suitable housing and supportive services in the community.

Who Should be Involved in Discharge Planning?

The most important person or entity that should be involved in discharge planning should be the transitioning youth. The case manager or case worker and exiting youth should work in partnership to develop an effective discharge plan. Important in this partnership, the case worker or case manager facilitates the youth's identification of strengths, meaningful adults, and goals. The identification of an adult important to an emancipating foster youth is not only essential in the discharge process but also a State mandate by California's Assembly Bill 408, which went into effect January 1, 2004 (California Welfare and Institutions Code § 16501(b)(11)). In recognizing the importance of meaningful adults in the lives of foster youth, the law provides for these adults to be included in the development of transitional living plans.

Across the literature it has been clear that collaborations be formed to create cross-system dialogue between child welfare agencies and other state and community based agencies invested in young people. The coming together of these entities is important in alleviating the red tape and difficulties of navigating through the sometimes complicated systems of services. It is the hope that the varying systems work together to share resources and ultimately map out a multi-system flow of services available to transitioning youth.

⁸⁵ Casey Family Programs, 2001



An important entity in this collaboration should include housing authorities to meet the housing needs of young people exiting the system. The Child Welfare League of America (CWLA) illustrates that “a cross system collaboration and coordination between the child welfare system, adult services, mental health and the housing authority can ensure that a youth with special needs is in a supportive housing program and linked to appropriate services upon discharge from the foster care system.”⁸⁶

Elements of Successful Discharge Planning

Successful discharge planning for youth exiting foster care needs to be guided by basic elements that set their successful transition to adulthood. In addition, child welfare providers need to ensure that ample time is allotted for discharge planning so that youth are adequately prepared to transition out of foster care. A report released by the CWLA encapsulates the essential components of the discharge process found throughout the literature. The report summarize that every young person aging out of foster care is entitled to a wide array of supports, resources and services to ensure safe, stable and affordable housing upon discharge. The CWLA reports that youth need the following as part of the discharge process when exiting the foster care system:

- To work in partnership to develop an effective discharge plan with their case manager;
- To have opportunities to practice living on their own prior to exiting foster care;
- To have access to safe, stable and affordable housing prior to discharge;
- To have a permanent connection in their lives;
- To have access to resources, services and financial supports that promote and support long-term success and positive housing outcomes

⁸⁶ Torrico, R. (2004). Child Welfare League of America independent living coordinator questionnaire results. Child Welfare League of America. <http://www.cwla.org/programs/housing/housingpubspage.htm>



Not identified by the CWLA is the importance of two additional key elements identified by the Casey Family Programs' model framework *It's My Life*. The framework determines that cultural and identity formation, as well as access to services that promote positive physical and mental health, are important to a young adult's successful transition out of foster care. The CWLA further summarizes the literatures findings into the following recommendations. See *Appendix F*:

- No foster youth should leave the foster care system without a solid, effective transition plan.
- Young people in foster care need to be given the opportunity to learn and practice life skills before actually living on their own.
- No foster youth should leave the foster care system without permanent connections.
- No foster youth should leave the foster care system without being financially literate.
- No foster youth should exit the system without knowledge about the programs, policies, community resources and federal funding streams that is intended to help them successfully transition into adulthood.
- No foster youth should be discharged from foster care without access to higher education, employment, medical insurance, safe, stable and affordable housing and a permanent connection.

These recommendations are more specific in addressing the relevant roles and responsibilities of the involved parties and summarize the action elements of a comprehensive discharge plan⁸⁷. The recommendations include:

- The adoption of a team approach to facilitate communication and the effective use of resources
- Team members must be able to commit resources (e.g., information, staff time, and services) to the discharge plan.
- The team leader, usually the case worker, will be responsible for the youth's re-entry into the community.
- The designation of a single organization to be fiscally and legally responsible for coordinating the activities of all entities involved in the discharge planning.
- The development of information systems that link institutional and community settings for improving communication, facilitating access to resources, and tracking completion of the discharge plan.
- Privacy concerns must be fully addressed when implementing such information systems.

⁸⁷ Moran, G., Semansky, R., Quinn, E., Noftsinger, R., & Koenig, T. (2005). *Evaluability assesment of discharge planning and the prevention of homelessness. Final Report*. Rockville, Maryland: WESTAT.



Examples of Model Programs

It's My Life Through extensive review of literature and focus groups with varying stakeholders, the Casey Family Programs developed the *It's My Life* youth-centered frame-work for youth transitioning out of foster care to adulthood. The framework is not a discharging plan document but rather an assessment available online that considers nine domains: Career planning; communication: daily living; home life; housing and money management; self care; social relationships; work life; and work and study skills. Once completed by the youth and case worker, a report is regenerated to assist in identifying greatest life skill's strengths and areas with opportunities for growth. Having this assessment become part of a discharge plan prepares the youth to transition to adulthood. See Appendix G for a logic model of the program. The framework is developed to assist youth in discovering their strengths and resiliency in order for them to envision leading self sufficient lives. The framework is free to use for organizations providing services to youth leaving care. The *It's My Life* assessment can be accessed through the following website: <http://www.caseylifeskills.org>.

Recommendations for Providers

In order to successfully plan discharge from foster care the following recommendations must be considered and addressed:

1. Youth must work in partnership with a case manager to plan their discharge.
2. Foster youth should leave with a solid and proven effective plan.
3. Foster youth must be given the opportunity to practice life skills before discharge.
4. Foster youth must have permanent connections to adults and support systems.



Chapter Four: Discharge Planning for Prisons and Jails

Each year, more than 650,000 people are released from state prisons in the United States, and an estimated nine million are released from jails.^{88 89} The number of people released from prison has increased 350 percent over the last 20 years.⁹⁰ During the same time period, the number of people who are homeless has swelled dramatically, to the current level of up to 754,000 people on any given day.⁹¹

The California Department of Corrections and Rehabilitation (CDCR) reports that at any given time 10 percent of the state's parolees are homeless, and in major urban areas such as San Francisco and Los Angeles, the percentage of parolees who are homeless is as high as 30 to 50 percent.⁹² No real time count exists for homeless parolees and

At any given time, 10 percent of California's state parolees are homeless and in urban areas the numbers can be as high as 30 to 50 percent.

probationers according to both Departments since neither record this system-wide or have available for public reporting. While unstably housed, these homeless parolees and probationers are at a greater risk for potential revocation of community supervision, often allowing them to re-cycle through the penal system. Prison and jail are among the most expensive settings to serve people who are homeless: one nine-city study calculated median daily costs for prison and jail at \$59.43 and \$70.00 respectively, compared with \$30.48 for supportive housing.⁹³ Supportive housing has been documented to drastically reduce criminal justice involvement; reducing jail incarceration rates up to 30 percent and prison incarceration rates up to 57 percent.⁹⁴

⁸⁸ Prison and Jail Inmates at Midyear 2005, NCJ 213133

⁸⁹ Allen Beck, Urban Institute 2006

⁹⁰ James P. Lynch and William J. Sabol, Urban Institute 2001.

⁹¹ HUD's first-ever Annual Homeless Assessment Report to Congress

⁹² California Department of Corrections, *Prevention Parolee Failure Program* 1997

⁹³ The Lewin Group. 2004, Costs of Serving Homeless Individuals in Nine Cities

⁹⁴ Housing Policy Debate, Vol. 13, Issue 1. Fannie Mae Foundation 2002



Persons facing discharge from a correctional institution wonder where will they sleep once released. For those who cannot return to the home of family or friends, the question of housing becomes considerably more complex. For some, the final answer is a homeless shelter or the street. The few that receive addiction treatment while incarcerated hope for a bed in a community residential program. Studies show reduced recidivism when corrections based treatment is followed by community aftercare.

Reentry is the process of leaving custody and returning to community. Ninety percent of all prisoners will at some point return to the community. This document will describe the scope of one aspect of the reentry issue: the intersection of reentry, housing, and homelessness and the barriers returning prisoners face in accessing temporary and permanent housing. The promising practices emerging across the country will also be highlighted.

Scope of Problem and Data Elements

The enormity of California and Los Angeles and the multiple government entities responsible for public safety make reentry strategies difficult, largely because of school of thought differences with homeless and reentry advocates, rather than research. At the end of every discussion about prisoners exiting custody to community, everyone wants to know who is paying the bill and whether it will be passed on to the tax payer. Currently, crime prevention and reduction for public safety is at the pedestal to win support for elected office or popular positions in the public eye. However, what has lacks in most promissory speeches is that the strategies put forth when held to the fire lacks sensibility, inclusive input, and reality testing and for these reasons fail to save government and tax payers money and most importantly the human tragedy of offenders returning to communities homeless with only a return to custody insight.

As of March 31, 2008, according to Department of Corrections and Rehabilitation, Data Analysis Unit, Los Angeles Parole Region 3 had 38,651 parolees in the community with factoring an estimated 30 to 50 percent calculation used in there 1997 study generates an estimated 11,695 to 19,325 homeless parolees. While as of the same date according to an interview with an administrator in LA County Probation approximately 62,000 adults are on probation and 1,862 are homeless. The potential for community supervision standards and oversight in each department appear to be key factors on impacting homelessness or the practice of County and State facility discharging practices.



Incremental California and Los Angeles efforts are being made to prepare mentally ill and HIV/AIDS offenders while California alone operates a component for serious violent offenders. Each effort includes pre-release planning or transitional case management that consists of in-custody release planning and post-release follow up. Each is financed by government and operated by non profits or special divisions in the financing government entity. These targeted efforts require special population designation eliminating the large amount of unidentified homeless entering the penal system.

However, Sheriff Leroy Bacca, Los Angeles Sheriffs Department who operates the nation's largest jail system, created a Community Transition Unit (CTU) to provide discharge planning and release preparation services across the seven sites of the 20,000 plus bed county jail to general homeless without special population designation. The level of need within the jail, and community housing provider and public policy barriers continues to trump the ability of the CTU to provide services limiting their ability to effectively and efficiently connect inmates to housing upon release.

Scope of Problem in Los Angeles County

The ability of the non profits working in corrections and custody staff to provide discharge planning is limited by facility environments and protocols. The corrections environment, by definition, is not naturally suited for building trusting relationships that are needed for accurate offender reporting of information and needs instrumental to proper adequate pre-release planning. The structure and size of LA County jails and CA prisons, each with their own protocols, makes it difficult to standardize practices and form an organizational identity across sites. One of the most challenging aspects of working within the LA jail systems is unpredictable release dates that too often occur and negatively affect successful transition from custody to community housing or addiction treatment. Because of overcrowding in the LA County jail system, custody staff often need to determine inmate releases on the day of release. For those who are detainees, clients may be released directly from court and return to jail only to collect their belongings. The uncertainty around release dates makes it difficult to adequately plan for community-based placements and ensure transportation to housing and programs.

Many offenders lack valid California Identification at the time of release. This issue is often identified as a national problem in the research literature. Many people leaving jail and prison do not have their birth certificates, social security cards, or any other form of valid identification. One of the recommendations of the 2004 report of the Reentry Policy Council, Charting the Safe and Successful Return of Prisoners to the Community, is to assist inmates/prisoners in obtaining valid identification.



The Council reports that without appropriate identification, it can be difficult to obtain housing, employment, or public benefits, and in turn, medication or medical treatment. Identification is also needed to cash paychecks or open a bank account.⁹⁵

The US Department of Housing and Urban Development (HUD) charges Public Housing Authorities (PHAs) with maintaining safe housing communities, but permits significant discretion in determining admission policies: only individuals who are subject to lifetime registration under a state sex offender registration program and those who have been convicted of the manufacture or production of methamphetamine in federally assisted housing are barred for life.⁹⁶ The United States Code contains the official federal definition of homeless. In Title 42, Chapter 119, Subchapter I, homeless (c) Exclusion does not include any individual imprisoned or otherwise detained pursuant to an Act of the Congress or a State law. However, HUD Supportive Housing Programs may assist someone that was incarcerated that can document being discharged from jail/prison, in which the person has been a resident for more than 30 consecutive days and no subsequent residence has been identified and the person lacks the resources and support networks needed to obtain their own housing. HUD Supportive Housing Programs fund Transitional Housing, Permanent Housing for People with Disabilities, Safe Havens, Innovative Supportive Housing, and Supportive Services Only.

However, the Housing Authority of the City of Los Angeles (HACLA) and the Housing Authority of the County of Los Angeles (HACoLA) have Administrative Plans (Plan) that limit housing opportunities for people with criminal backgrounds beyond the federal requirements, such as HACoLA Plan, Section 2.8.1 Criminal History Screening Standards that require a family to certify they will not allow adult incarcerated family member once released reside in or visit family household and Section 2.8.1, Sub Section 8, states that HACoLA shall deny admission if the applicant or household member has not completed parole and probation including summary probation. Both rules create barriers to accessing housing that increase odds of becoming homeless after incarcerated. Even though the Shelter Plus Care program does not require criminal background checks, most program operators exercise similar exclusionary practices during screening applicants since there is no transparency required by these operators to the public that it is available for people with criminal backgrounds.

⁹⁵ Reentry Policy Council, Charting the Safe & Successful Return of Prisoners to Community 2003

⁹⁶ 24 Code of Federal Regulations 982.553 and 882.518



To complicate this matter, HACLA Plan Chapter 13 Terminations and Denials has a slightly softer path without blanket denial to housing for people on parole or probation, however without certification HACLA does require assisted families to deny an adult incarcerated family member with a history of alcoholism or drug addiction once released to reside in household without verifiable documentation that he or she successfully completed a supervised drug rehabilitation program since the last instance of illegal drug use or is currently an active participant in a supervised drug rehabilitation program. Given the lack of corrections-based substance abuse treatment the likelihood of providing this documentation upon release to satisfy this requirement only increases the odds of not returning home, and favors falling into homelessness.

Too often, corrections are blamed when both custody and community systems and policies need integration. The California Department of Corrections and Rehabilitation and Los Angeles County Probation Department consider housing a paramount issue in ensuring successful re-entry and preventing recidivism. By providing supervision, services, and (in some cases) financial support that encourage housing stability, corrections agencies are valuable partners.

Value of Conducting Discharge Planning

Correctional facilities regularly release individuals back into society with little or no support upon exit. The lack of support and/or proper planning increases the likelihood of individuals returning to jail, mental health facilities, or relapse into addictive behaviors. Planning for individuals who are incarcerated should begin upon their admission into a facility to ensure that sufficient time is given to develop a comprehensive plan. The following are some of the impacts poor or no discharge planning can have:

- Increased dollars have funded operating costs for more prisons, but not more rehabilitation.
- Recycling parolees and probationers in and out of families and communities has a number of adverse effects: detrimental to community cohesion, employment prospects and economic well being, family stability, childhood development, mental and physical health and exacerbates such problems as homelessness.

Therefore, the benefits of conducting discharge planning from custody are:

- Linkage to appropriate next step resources based on needs; reduces reverting to methods of survival that often are self destructive
- Prevent vulnerable populations from becoming homeless
- Investment in outcome that every life has some human potential to be productive member of society
- Maintain gains achieved during the course of incarceration



Discharge Planning Model

An integrated model for prisoners and inmates requires that each member of the discharge planning team has competency in case management with emphasis on assessment, intermediate counseling skills, and pre-release case planning. Additional competencies are needed when assisting populations such as but not limited to those with; HIV/AIDS, mental illnesses, homelessness, and co-occurring disorders. It is beneficial to have corrections staff responsible for discharge planning to be cross-trained on-the-job to meet adequately the needs of all populations exiting the correctional system.

Within the correctional setting, this means training in these areas:

- Recognizing and understanding criminal behavior
- Understanding the relationships between criminal behavior and different maladaptive coping skills
- Individualizing and modifying approaches to meet the needs of specific prisoners or inmates to achieve engagement, retention in pre-release planning, and linkage with follow up in community based setting.
- Accessing custody and community resources from multiple systems

Who Should be Involved in Discharge Planning?

Inmate/Prisoner and correctional counselor or the custody-based non profit equivalent, including correctional medical and mental health staff need participate in creating the discharge plan, as well as consulting community partners that may exist from inmate/prisoner's past before incarceration, plus new resources brought on board for the case. It is imperative that discharge planning for the inmate/prisoner with mental illness or co-occurring disorders ensures continuity of psychiatric assessment and medication management, without which compromises stability and recovery potential. This is true in cases where HIV/AIDS exist that will require medical and nutritional assessment plus proof of TB clearance for most community facilities to receive people released from corrections. Also, supportive family and friends in the community may assist with community transition preparatory foot work.



Elements of Successful Discharge Planning

Based on the work of the National GAINS Center 2002, APIC, or Assess, Plan, Identify and Coordinate, give clear appropriate activities to guide the function of everyone involved in discharge planning that is feasible for correctional and community agency policy and procedures. Even though APIC was created for jail facilities it is the opinion of many to be applicable to prison settings. Here are the APIC elements to be applied in the discharge process:

- Assess the clinical and social needs, and public safety risks
- Plan for the treatment and services required to address needs
- Identify required community and correctional programs responsible for post release services
- Coordinate the transition plan to ensure implementation to avoid gaps in care with community based community services

Accordingly, the following elements are necessary to ensure successful discharge planning of prisoners and inmates:

1. The plan needs to anticipate the common mishaps with jail and prison release operations.
2. The plan needs to have a back up plan.
3. Discharges to mass sheltering are often non conducive to assimilation to community.
4. Planning must be individualized, comprehensive, and coordinated with community based services.
5. Consumers must participate in the planning.
6. Institution staff (inclusive of professional staff) and community partners should be included.
7. For consumers who abuse substances or live with medical conditions or mental health problems, appropriate treatment and care in community must be arranged, including the filling of medication and collecting of medical records to be in hand upon release to not interrupt treatment during transition.
8. Proper State identification and transportation assistance to access community resources to achieve linkage.



Examples of Model Programs⁹⁷

Faith Works! The Miami-Dade County Corrections and Rehabilitation Department created the Faith Works! Aftercare Program, a 12-month, 3-phase program based on the idea that religious beliefs can effect positive change behavior and empower an inmate to overcome obstacles and barriers that may contribute to criminal behavior. Housed separately from the general population to maintain program integrity, each participating inmate, or client, is assigned a faith mentor and a case manager that act as liaisons to the community and church and who work to leverage existing social and educational services in jail and in the community.

Frequent User Services Enhancement The Corporation for Supportive Housing, New York City Department of Homeless Services, and New York City Department of Corrections, as part of their ongoing collaboration to improve discharge planning among inmates at the city jail created the Frequent User Services Enhancement Project. After conducting a data match, 1,000 individuals who repeatedly cycle in and out of the city's jail and shelter systems were found. The New York City Frequent Users of Jail and Shelter Initiative was conceived in 2004 as the Corporation for Supportive Housing (CSH) worked with the DOC and the DHS to identify those who, at a minimum, have had four shelter and four jail admissions over the past five years. During 2005, the CSH and the city agencies designed and implemented a supportive housing demonstration of 100 units, leveraging existing housing and service opportunities including 50 Section 8 vouchers from the New York Housing Authority targeted toward frequent users with a substance abuse diagnosis, 50 vacancies in New York/New York city-state initiative and other supportive housing projects targeted toward frequent users with serious and persistent mental illness or substance abuse diagnosis, and 9 nonprofit organizations who agreed to provide housing and support to frequent users. The JEHT foundation has awarded an additional \$650,000 to create the Frequent User Services Enhancement (FUSE) fund to provide a high intensity of services and supports in supportive housing settings to 100 individuals during their first year of tenancy. After this first year, service intensity reduces to a level more typical of supportive housing settings.

Rikers Island Discharge Planning Enhancement Program The New York City Department of Correction and Department of Homeless Services created the Rikers Island Discharge Planning Enhancement Program (RIDE) is a citywide collaborative discharge planning program that seeks to engage sentenced inmates in discharge planning services to prepare for release, motivate inmates to take advantage of postrelease services in the community, and prevent reincarceration and homelessness.

⁹⁷ Life After Lockup: Improving Reentry from Jail to the Community, 2008



Transitional Case Management The Tarzana Treatment Centers (TTC) seek to improve public health and safety by providing transitional case management services and postrelease follow-up to inmates in the Los Angeles County Jail who are living with HIV/AIDS. Eligible inmates are individually assessed at intake, and a transitional case manager works with them to develop and implement a release plan that focuses on access to appropriate health care, financial assistance, counseling, housing, transportation, and other supportive services after release. Regular follow-up and periodic reassessment of needs continues in the community up to six months after release.

Recommendations for Providers

The following recommendations for providers offer evidence-based solutions to the problem of poor discharge planning in the jail and prison systems.

1. If you don't already have one, establish a discharge planning work group reflective of the various departments/services provided by your agency.
2. Develop a uniform discharge planning process for individuals exiting your system of care.
3. If you already have a written protocol, revisit your discharge and aftercare policy and procedures and assess whether they are appropriate for individuals who are homeless or at risk of becoming homeless.
4. Provide training to all staff involved in discharge planning to ensure some degree of uniformity in the implementation of your written protocol. If resources allow, evaluate whether staff are following protocol and adhering to written guidelines.
5. Have relationships already been developed with agencies to which clients are being discharged and is their policy and procedure of accepting discharges consistent with your discharge P & P.
6. If resources allow, collect data on outcomes of your discharge procedures.



Appendix



Appendix A: Mental HealthTemplate of Discharge Plan⁹⁸

Section 1: Referral Information		
Referral Source:	(E.g. CDC, Hospital, FSC, etc)	
External Referral No.:		
Date of Referral:	Date of Receipt:	
Name of referrer/ Designation:		
Contact Numbers (Office, Mobile, Email:)		
Current Location of Client:		
Section 2: Client's Information		
Case Reference		
Name		
NRIC		
Contact nos. (Home, Mobile, Email)		
Address:		
Religion	Gender	
Preferred Language/Dialect	Ethnicity	
Date of Birth	Age	
Section 3: Caregiver's Information		
Has Primary Caregiver	Yes <input type="checkbox"/> No <input type="checkbox"/>	Relationship to client :
Name of Caregiver/Guardian/ Next of Kin		
Occupation:		
Address		
Contact Numbers (Home, Office, Mobile, Email)		
Nationality	Marital Status	

⁹⁸ Source: Appendix III <http://www.ncss.org.sg/documents/CareandDischargeGuide-Jan-final6.pdf>

Section 4: Intake Assessment	
Presenting Problem	
Underlying Problem	<i>E.g. Abuse/Neglect; Addiction; Care Arrangement/ Shelter; Care-giving Issues; Elderly Issues; Employment Issues; Family Issues; Financial Issues; Health Issues; Housing Issues; Immigration Issues; Interpersonal Issues; Learning Disability; Marital Issues; Mental Health Issues; Psycho-emotional issues; Sexual Issues; Substance Abuse; Suicide, others.</i>
No. of needs	No. of needs met
If accepted	
Reason for acceptance & date:	
If not accepted	
Referred to:	<i>Name of Organization</i>
Name of Receiving Staff/ Designation	
Remarks	
Section 5: Needs Assessment (if necessary by a multi-disciplinary team)	
Date created	Review date
Staff in charge	<i>Name and Designation</i>
Other staff involved	<i>Name and Designation</i>
Functional Assessment	<i>Include ability to perform Activities of Daily Living such as feeding, grooming, bathing, dressing, toileting, mobility; Instrumental Activities of Daily Living (using the telephone, grocery shopping, preparing meals, doing housework and laundry); etc. Assessed by: (Name & Designation) Date:</i>
Educational Background & Career History	<i>Include name of school, level and general academic performance for students. Include highest qualification and work history for adults. Assessed by: (Name & Designation) Date:</i>
Medical History	<i>Include nursing needs, RAF status, place of medical follow up, etc Assessed by: (Name & Designation) Date:</i>



Financial Profile	<p><i>Include reasons for financial difficulties, for e.g. alcoholism, certified permanently incapacitated; chronic illness; drug addiction; family relationship problems, gambling, imprisonment (prison/DRC); in debt or bankruptcy; irregular/not receiving maintenance; irregular employment; large family; low wages; non-contribution from other wage earners; physical/intellectual disability; poor budgeting; unemployment; others.</i></p> <p>- Family Means Test Information</p> <p>- Financial Assistance (if any)</p> <p>- Charges and Fees, including transport fees if any.</p> <p>Assessed by: (Name & Designation)</p> <p>Date:</p>	
Psychological Profile	<p><i>Include general assessment for e.g. risk or history of abscondence, misconduct, violent behavior, suicidal attempt, substance abuse, non-substance abuse, medical, others.</i></p> <p><i>Include observation of behavior for e.g. aggression, task, anxiety, repetitive behavior etc.</i></p> <p>Assessed by: (Name & Designation)</p> <p>Date:</p>	
Social History	<p><i>Include information of next of kin and caregivers, as well as information on formal and informal support network.</i></p> <p>Assessed by: (Name & Designation)</p> <p>Date:</p>	
Strengths/Abilities		<p>Assessed by: (Name & Designation)</p> <p>Date:</p>
Interests (e.g. hobbies)/ Stated or Known Preferences		<p>Assessed by: (Name & Designation)</p> <p>Date:</p>
Section 6: Interpretive Summary		
Caseworker's Diagnosis		<p>Assessed by: (Name & Designation)</p> <p>Date:</p>
Section 7: Care Plan		



Description (Aim)		Date set	Review date	Outcome
Goals and Measures	Goal Type (Long-term/short-term)	Date set	Review date	Outcome
1.				<input type="checkbox"/> Achieved <input type="checkbox"/> Partially - Achieved <input type="checkbox"/> Not
2.				<input type="checkbox"/> Achieved <input type="checkbox"/> Partially - Achieved <input type="checkbox"/> Not
3.	<input type="checkbox"/> Achieved <input type="checkbox"/> Partially - Achieved <input type="checkbox"/> Not achieved			
4.	<input type="checkbox"/> Achieved <input type="checkbox"/> Partially - Achieved <input type="checkbox"/> Not			
Action Plan/Strategies				
Progress Notes				
<i>Note changes in client needs and circumstances and changes to care plan.</i>				
Section 8: Discharge Plan				
<i>Include role of client, family, community, other agencies and resources</i>				
Date of closure		Initiated by:		
Reason for closure				
Goals achieved				
Completion of Goals				
Caregiver satisfaction survey		Is Survey Conducted; Level of Caregiver Satisfaction/ Comments		
Duration of stay (days)				
Organization referred for follow-up				
Staff responsible for follow-up				
Date of planned follow-up				



Name of staff and contact details given to client	Tel: Email:
Client's signature/ Date	
Case manager's signature/ Date	
Approved by:	<i>(Name, Designation and Signature, Date)</i>



Appendix B: Mental HealthDischarge Plan Checklist⁹⁹

Discharge Plan Checklist	Yes	No
1. The client's strengths, needs, abilities and preferences (SNAP) at the point prior to discharge are documented.	<input type="checkbox"/>	<input type="checkbox"/>
2. The gains from participating in the program, or goals achieved are documented.	<input type="checkbox"/>	<input type="checkbox"/>
3. The likely post-discharge needs and issues are identified and conveyed to client and caregiver, if any.	<input type="checkbox"/>	<input type="checkbox"/>
4. Referral to other agencies for post-discharge needs are made, where necessary.	<input type="checkbox"/>	<input type="checkbox"/>
5. Caregivers are briefed on client needs, and informed with other resources available, including caregiver support groups, respite services and other community resources.	<input type="checkbox"/>	<input type="checkbox"/>
6. Contact details of a staff from the discharging organization have been given to client and caregiver.	<input type="checkbox"/>	<input type="checkbox"/>
7. A designated staff had been assigned to follow-up with the client and caregiver, within a specified time-frame.	<input type="checkbox"/>	<input type="checkbox"/>
8. Information resources, such as pamphlets of community-based services, health-related information (disease prevention, nutrition or diet, coping skills for caregivers, etc.) had been given to client and caregiver.	<input type="checkbox"/>	<input type="checkbox"/>

⁹⁹ Source: Appendix II <http://www.ncss.org.sg/documents/CareandDischargeGuide-Jan-final6.pdf>



Appendix C: Hospitals

KFH Regional Protocol on Homeless Discharge Planning

It is the policy of Kaiser Foundation Hospitals (KFH) to manage the care of the homeless patient with the same dignity and compassion that all patients should expect to receive at the KFH hospital. Prior to discharge, an appropriate discharge plan for post-hospital medical care will be completed and clearly documented in the medical record.

To improve continuity of care and better address the particular health care needs of the homeless patient population, KFH hospitals in Los Angeles County are committed to the following protocol for discharge planning for its homeless patients.

1) Identifying Homeless Patients. Registration staff, nursing staff, or other members of the health care team will seek to identify homeless patients as soon as possible after admission.

a) Homeless patient means any person who lacks a fixed and regular nighttime residence, or who has a primary nighttime residence that is supervised publicly or privately operated shelter designed to provide temporary living accommodations, or who is residing in a public or private place not designed to provide temporary living accommodations or ordinarily used as a sleeping accommodation for human beings.

b) Identified homeless patients will be captured in hospital homeless patient logs to enable better monitoring of care and services provided to the homeless and to assist in identifying barriers to continuing health care in the Los Angeles community.

2) Belongings. Admitting and emergency department nurses will document the belongings of the patient and return these belongings upon discharge. If patient belongings do not include adequate clothing, KFH hospitals will provide adequate clothing to the patient.

3) Mental Status

a) KFH practitioners recognize that homeless patients may be at greater risk of mental illness or other conditions that affect cognitive intactness (meaning the absence of cognitive impairment that could interfere with the patient's ability to understand and make informed decisions about treatment options and to follow post-discharge care plans or to effectively negotiate the community in which he or she resides).

b) Accordingly, treating physicians, nurses, and consulting social workers will assess and document the mental status of homeless patients during their clinical examinations or assessments over the course of the patient's hospital stay to determine whether the patient is cognitively intact. Based on such assessment, additional services or referrals may be clinically indicated depending on mental status, such as referrals for additional cognitive or neurological evaluation, inpatient mental health treatment, outpatient mental health referrals, assistive care, involuntary (Welfare & Institutions Code § 5150) holds, or conservatorship.

c) When developing discharge plans, hospital nursing staff, discharge planners and/or social workers will evaluate and document the patient's cognitive intactness, including his/her understanding of and ability to implement the plan. The assessment of a patient's cognitive intactness will consider, and will be appropriate to, the patient's individual



circumstances (e.g. the patient's living circumstances and available support system post discharge) and the complexity of the discharge plan to be implemented, but considerations will include the patient's orientation to person, place, circumstance and time, his or her ability to provide self care and the ability to secure needed follow-up medical care, food and emergency shelter.

d) If any member of the treatment team questions the patient's cognitive intactness to follow a discharge plan, the discharge will be delayed until the concern is addressed and appropriately resolved.

4) Discharge Planning

a) In recognition that homeless patients face particular barriers to ongoing medical care and have complex medical and social service needs, the discharge planning process will begin as soon as possible after hospital admission.

b) The treating physician is responsible for determining clinical stability for discharge and identifying post-hospitalization medical needs.

c) A social worker will conduct a social services needs assessment for homeless inpatients. In the Emergency Department, nursing staff or the treating physician will request a Social Services consult when indicated for social services needs. Social services needs may include the need for food, shelter, substance abuse treatment, treatment for (or protection from) domestic violence, vocational assistance, Medi-Cal enrollment eligibility for DMH mental health services, application for financial assistance (SSI, etc.) or other supportive services.

d) A discharge plan for transition to the community will be developed with the participation and agreement of the patient, or appropriate surrogate decision-maker and will be appropriate to the patient's medical and social services needs. Barriers to appropriate discharge will be identified and addressed.

i) For patients in need of ongoing inpatient care (e.g. specialized hospitalization, skilled nursing), transfers will be arranged in compliance with hospital policy and applicable law.

ii) For patients with assistive care needs (e.g. assistive living, recuperative beds, board and care) or outpatient medical or mental health needs, nursing staff (emergency department) or discharge planners (inpatient). In consultation with social services, will assist the patient with referral options.

iii) For patients with social services needs, social workers (or sometimes nursing staff in the emergency department) will provide assistance with referrals to service providers and government agencies for needs identified in the social services needs assessment conducted pursuant to Section IV (C), if accepted by the patient.

e) Patients will be discharge with appropriate clothing.

f) Documentation of discharge planning will include completed discharge instructions with patient name and signature, documentation of the patient's cognitive intactness,



and documentation that the patient understand and agrees with the discharge plan, including medications and follow-up care.

5) Referral to Shelters

a) Social services will assist all patients who request shelter referral post-discharge.

b) The social worker will ascertain the patient's wish for a shelter referral and identify the patient's current geographic residence and preferred geographic residence, if they are different. In addition to a shelter, other community organizations serving the homeless may also be considered to assist with shelter alternatives. Efforts will be made to secure shelter/community-based housing within close proximity to the area where the patient resides, unless the patient makes a specific request for a different location.

c) The social worker will assure that the patient meets the shelter's criteria for acceptance (e.g. gender limitations) and is appropriate to those criteria (e.g. patient expresses willingness to abide by prohibitions on substance use, and is able to follow instructions from the shelter to access shelter services, such as complying with pick-up location restrictions for shelters that do not permit direct transportation to the shelter). The social worker will document the patient's agreement to the shelter and the shelter's acknowledgment that it can provide shelter to the patient (for shelters that are willing to have direct discussions with hospitals).

d) Criteria for Referral to Skid Row Shelters. KFH hospitals recognize that although many services available to the homeless are concentrated in Skid Row, this environment is not appropriate for all homeless individuals. Skid Row shelters will be a destination of last resort for hospital patients that are homeless. In addition to the above elements, KFH hospitals will adopt the following protocol for discharge to Skid Row shelters:

i) KFH hospitals will assist patients with referrals and transportation to Skid Row shelters only if the patient currently resides in the Skid Row area or requests and specifically agrees to placement with a Skid Row service provider, after discussion of other non-Skid Row options, if available.

ii) The social worker will evaluate the patient's cognitive intactness to negotiate the Skid Row area, based on training to be provided regarding considerations specific to this area, and will document this determination.

iii) The social worker will contact available shelters, identify an accepting shelter, and confirm that the patient meets its acceptance criteria. The social worker will document the above contacts and acceptance.

iv) The social worker will provide the patient with information regarding resources for other supportive services available in the Skid Row area that the patient may need.

v) Patients will be transported to the shelter by van transportation. Transportation staff will assist the homeless individual as needed in entering the shelter and making contact with shelter staff or otherwise accessing shelter services (e.g. identifying where the individual is to wait in line for services).



vi) Prior to discharge, the Hospital Administrator, or designee, will review and approve the discharge plans of all homeless patients being transported to Skid Row service providers.

6) **Community Resources.** KFH hospitals will establish and build relationships with community services providers to assure accurate contact information and acceptance criteria for community services and to maximize resource availability for KFH patients.

7) **Accountable Executive.** The Executive Director at each KFH hospital is accountable for assuring ongoing compliance with this Protocol.

8) **Training**

a) KFH will establish initial and periodic training reasonably designed to ensure that hospital physicians, clinical staff, social services and discharge planning personnel, and other hospital staff who are most likely to be involved in discharge planning and discharge of homeless patients receive training regarding the procedures required by the Protocol.

b) The above personnel will be provided training in the following areas, as applicable to their role in the discharge planning process: (1) implementation and application of the Homeless Patient Discharge Protocols; (2) the nature and extent of homelessness in Los Angeles County; (3) the mental and physical problems typically faced by homeless persons in Los Angeles County (4) assessing the presence or lack of cognitive intactness in homeless persons who present for treatment; (5) the post-discharge care issues that distinguish the discharge planning for homeless persons from that of the general patient population; (6) the need for effective communication with homeless persons regarding their post-discharge care; (7) the location and limitations of shelters or services for homeless persons in the Skid Row area of the City of Los Angeles; (8) the nature, location and limitations of homeless shelters or services in other area in Los Angeles County; (9) appropriate referrals to government agencies and non-government service providers that can assist homeless patients in obtaining benefits and other supportive services, including, without limitation, engaging and referring appropriate cases during the hospital stay to programs, such as those offered through the Department of Mental Health, where housing, medical care, food and clothing may be available to the homeless patient during his/her stay in the hospital or immediately following discharge; (10) the nature and extent of the hazards facing the homeless in the Skid Row area of the City of Los Angeles; and (11) the circumstances and procedures under which a surrogate decision maker may be required, including, but not limited to, appointment of a conservator or public guardian.

c) Training reference materials will be available at each KFH hospital.



Appendix D: Hospitals

California Discharge Planning Law

California Assembly Bill 2745 passed on September 29, 2006, and amended the California Health and Safety Code's Section 1262 to include the following:

1262.4. (a) No hospital, as defined in subdivisions (a), (b), and (f) of Section 1250, may cause the transfer of homeless patients from one county to another county for the purpose of receiving supportive services from a social services agency, health care service provider, or nonprofit social services provider within the other county, without prior notification to, and authorization from, the social services agency, health care service provider, or nonprofit social services provider.

(b) For purposes of this section, "homeless patient" means an individual who lacks a fixed and regular nighttime residence, or who has a primary nighttime residence that is a supervised publicly or privately operated shelter designed to provide temporary living accommodations, or who is residing in a public or private place that was not designed to provide temporary living accommodations or to be used as a sleeping accommodation for human beings.

1262.5. (a) Each hospital shall have a written discharge planning policy and process.

(b) The policy required by subdivision (a) shall require that appropriate arrangements for post hospital care, including, but not limited to, care at home, in a skilled nursing or intermediate care facility, or from a hospice, are made prior to discharge for those patients who are likely to suffer adverse health consequences upon discharge if there is no adequate discharge planning. If the hospital determines that the patient and family members or interested persons need to be counseled to prepare them for post hospital care, the



hospital shall provide for that counseling.

(c) The process required by subdivision (a) shall require that the patient be informed, orally or in writing, of the continuing health care requirements following discharge from the hospital. The right to information regarding continuing health care requirements following discharge shall apply to the person who has legal responsibility to make decisions regarding medical care on behalf of the patient, if the patient is unable to make those decisions for himself or herself. In addition, a patient may request that friends or family members be given this information, even if the patient is able to make his or her own decisions regarding medical care.

(d) (1) A transfer summary shall accompany the patient upon transfer to a skilled nursing or intermediate care facility or to the distinct part-skilled nursing or intermediate care service unit of the hospital. The transfer summary shall include essential information relative to the patient's diagnosis, hospital course, pain treatment and management, medications, treatments, dietary requirement, rehabilitation potential, known allergies, and treatment plan, and shall be signed by the physician.

(2) A copy of the transfer summary shall be given to the patient and the patient's legal representative, if any, prior to transfer to a skilled nursing or intermediate care facility.

(e) A hospital shall establish and implement a written policy to ensure that each patient receives, at the time of discharge, information regarding each medication dispensed, pursuant to Section 4074 of the Business and Professions Code.

(f) A hospital shall provide every patient anticipated to be in need of long-term care at the time of discharge with contact information for at least one public or nonprofit agency or



organization dedicated to providing information or referral services relating to community-based long-term care options in the patient's county of residence and appropriate to the needs and characteristics of the patient. At a minimum, this information shall include contact information for the area agency on aging serving the patient's county of residence, local independent living centers, or other information appropriate to the needs and characteristics of the patient.

(g) A contract between a general acute care hospital and a health care service plan that is issued, amended, renewed, or delivered on or after January 1, 2002, may not contain a provision that prohibits or restricts any health care facility's compliance with the requirements of this section.

1262.6. (a) Each hospital shall provide each patient, upon admission or as soon thereafter as reasonably practical, written information regarding the patient's right to the following:

(1) To be informed of continuing health care requirements following discharge from the hospital.

(2) To be informed that, if the patient so authorizes, that a friend or family member may be provided information about the patient's continuing health care requirements following discharge from the hospital.

(3) Participate actively in decisions regarding medical care. To the extent permitted by law, participation shall include the right to refuse treatment.

(4) Appropriate pain assessment and treatment consistent with Sections 124960 and 124961.

(b) A hospital may include the information required by this section with other notices to the patient regarding patient rights. If a hospital chooses to include this information along with existing



notices to the patient regarding patient rights, this information shall be provided when the hospital exhausts its existing inventory of written materials and prints new written materials.



Appendix E: Foster Youth

Discharge Plan Checklist

The following is a checklist for service providers to use as a guide to successfully transition youth out of foster care. The list was compiled from the literature presented throughout the chapter. It draws from a literature review inclusive of stakeholder focus groups, including foster youth, empirical data, and exemplary programs. In order for transitioning foster youth to lead self sufficient lives as adults, a case worker should work in partnership with the youth in formulating a solid discharge plan that provides them with:

- ☐ Housing options that provide access to safe, stable and affordable housing;
- ☐ Economic security, including employment;
- ☐ Access to higher education and/or vocational training;
- ☐ Medical insurance;
- ☐ The assistance to create a vision of their own success;
- ☐ The encouragement to gain a positive cultural and identity formation;
- ☐ The power to become self-determined instead of being passively acted upon;
- ☐ The opportunity to begin their preparation for transition as early as possible, including the opportunity to practice living on their own prior to exiting foster care
- ☐ The supportive services to facilitate the continual learning of life skills over time;
- ☐ The guidance to acknowledge their own individual needs and those of their community;
- ☐ The assistance to identify their own resiliency and strengths;
- ☐ The assistance to identify a reliable and support network inclusive of positive, trusting, and permanent relationships with adults and connections to external support systems, such as schools, religious organizations, cultural communities and youth groups;

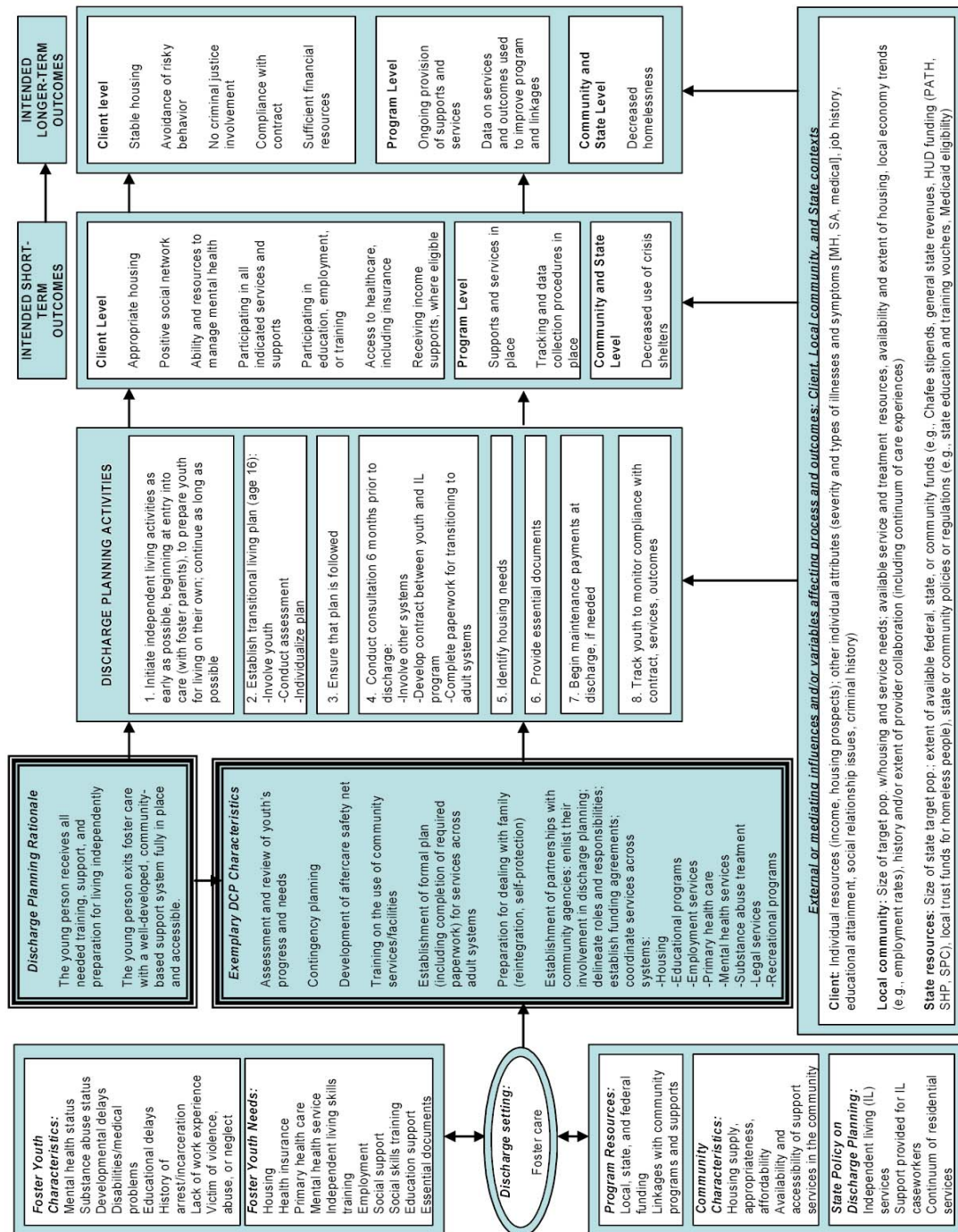


- ☐ The knowledge and access to community resources, programs, policies and financial supports, and federal funding streams that support short and long-term success and positive housing outcomes;
- ☐ The training to become financially literate;
- ☐ Assistance to acknowledge birth families and other significant relationships to assist with identity formation and personal history;
- ☐ The resources to develop the skills and competencies necessary to achieve their personal goals;
- ☐ Access to services that promote positive physical and mental health



Appendix F: Foster Youth Exemplary Discharge Plan¹⁰⁰

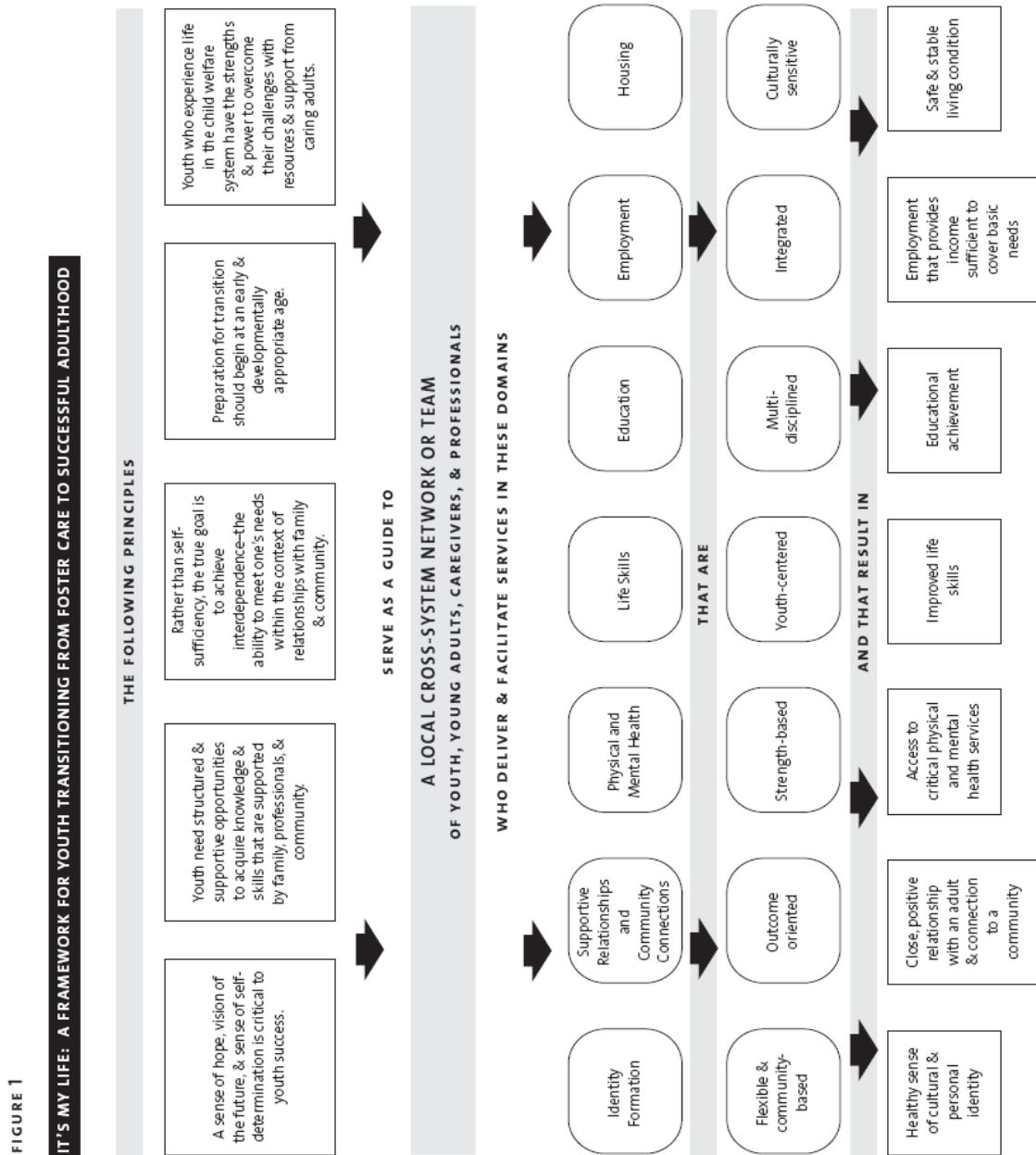
Exhibit 2: Preliminary Logic Model of Exemplary Foster Care Discharge Planning (DCP) to Avoid Homelessness



100 Moran, G., Semansky, R., Quinn, E., Noftsinger, R., & Koenig, T. (2005). Evaluability assessment of discharge planning and the prevention of homelessness. Final Report. Rockville, Maryland: WESTAT

assessment of discharge planning and the

Appendix G: Foster Youth It's My Life Logic Model¹⁰¹



¹⁰¹ Casey Family Programs (2001). It's My Life: Summary of a framework for youth transitioning from foster care to successful adulthood. <http://www.caseylifeskills.org>

Appendix H: Prisons and Jails

Program Contract Information

Faith Works!

Anthony Dawsey, Division Chief Miami-Dade County Corrections & Rehabilitation 2525 NW
62nd Street Miami, FL 33147
Tel: 786–263–6190
E-mail: Adawsey@miamidade.gov

Frequent User Services Enhancement

Richard Cho, Associate Director Corporation for Supportive Housing
50 Broadway, 17th Floor New York, NY 10004
Tel: 212–986–2966 ext. 249
E-mail: richard.cho@csh.org

Rikers Island Discharge Planning Enhancement Program

Sarah Gallagher Executive Director for Discharge Planning
60 Hudson Street, 6th Floor New York, NY 10013
Tel: 212–266–1409
E-mail: Sarah.Gallagher@doc.nyc.gov

Transitional Case Management- Tarzana Treatment Centers

Jose Rodriguez, Housing and Reentry Services Coordinator
Tarzana Treatment Centers
7101 Baird Avenue Reseda, CA 91335
Tel: 818–342–5897 ext. 2119
E-mail: jrodriguez@tarzanatc.org



Appendix I: Prisons and Jails

West Virginia Division of Corrections Appendix¹⁰²

Appendix A: Individual Reentry Program Plan Form

FORM C

West Virginia Division of Corrections Individual Reentry Program Plan

Name:				DOC/SSN #:		
Date Initiated:				Date of Revision:		
Case Supervisor:				PED:		
Behavioral Objectives:						Completion Type:
Program Resource/Service	Recommended	Enrolled	Completed	Grade	Participation	Withdraw

Staff Signature _____

Offender Signature _____

Original: Classification/Center/Parole Office File
Copy: Offender

¹⁰² West Virginia Division of Corrections Preparing Prisoners for Returning Home: A Process Evaluation of West Virginia's Offender Reentry Initiative Stephen M. Haas, Ph.D. Cynthia A. Hamilton, M.S. Dena Hanley, Ph.D. FINAL REPORT December 2007



Appendix B: WVDOC's Program Recommendation Matrix

FORM E

PROGRAM RECOMMENDATION MATRIX

Certain factors are tied to criminal behavior. By assessing and targeting these criminogenic needs we can reduce the likelihood of future criminal behavior. The most successful interventions are very focused and targeted to the needs that are related to risk. The major areas related to risk are measured on the LSI-R. They are listed in the following table with recommendations for programming. Please note that availability of the listed programs should be determined within your facility prior to making the recommendation. This list is not all-inclusive. There may be additional programs available that would benefit the offender within your facility and/or community.

Risk Factor <i>If this area is a high risk factor for the offender...</i>	Programs <i>...then, the following programs would be appropriate referrals</i>	Notes <i>Take note of the following when making referrals:</i>
Criminal History	Open Gate Cognitive Skills I-III Criminality 99 Days and a Get Up Transitions Diploma Thinking Skills Problem Resolution	<i>The more extensive his/her record, the more criminal history is considered a risk factor. First time offenders are less at risk; career criminals more so.</i>
Family Circumstances and Parenting	Cognitive Skills Critical Thinking 99 Days and a Get Up Transition Coordination Transitions Diploma	<i>Remember that the LSI-R addresses the risks facing the offender, not the risk he/she poses to others. This area addresses the impact of the offender's family on his/her rehabilitation, not the risk he/she might pose to the family.</i>
Education and Employment	Academic Assessment ABE/GED Post secondary training Vocational programming Hit the Ground Running Employment Maturity Job Search Life Skills 99 Days and a Get Up Transitions Diploma Ready to Work Diploma	<i>This includes all programs listed under academic and vocational programming.</i> <i>Students who have never been in the work force, or who have been removed from the work force for a long time will need these programs.</i> <i>Students with solid employment plans may NOT need these programs.</i>



Appendix C: Parole Release Plan Form

FORM M

West Virginia Division of Corrections
Parole Release Plan

Name:	DOC #:	Facility:	Race:	Gender:
Alias:	DOB:	SSN:		
County Sentenced:	County which to be paroled:			

Home Plan

Residence: Name:		Relationship:	
Address:			
City:		State:	Zip:
Phone:	In whose name:	At proposed home? <input type="checkbox"/> yes <input type="checkbox"/> no	
Location of Home:			

Employment/Education Plan

Employment, School, Other) Name:	
Address:	
City:	State: Zip:
Phone #	Contact Person: Title:
Type of work, school, other:	
Location:	
<i>To be filled in by Field Officer:</i> Date Received: _____ Date(s) investigated: _____ Date mailed to Central Office: _____	Facility Case Supervisor: Region/Director: Officer: Scheduled parole date: Date mailed to Central Office and Parole Officer: _____
Available funds upon release: \$ _____ Offense(s): _____ Sentence(s): _____	If granted: first release Conditions: <input type="checkbox"/> Mental Health <input type="checkbox"/> NA <input type="checkbox"/> AA <input type="checkbox"/> Other



Appendix D: Aftercare Plan Form

FORM N

**West Virginia Division of Corrections
Aftercare Plan**

Name:		Alias:	
County:	SS#:	DOB:	
Parole Office:		Parole Office Phone #:	
WV Job Service Office:			
Job Training Location:			
Health & Human Resources:			
Education Resources:			
Substance Abuse Support:			
Motor Vehicles Office (DMV):			

Other:
Other:
Other:
Scheduled appointments (who, what, when, where):

Original: Classification/Center File

Copy: Offender

Copy: Parole Officer Upon Parole





Appendix E: Program Category and WVDOC IMIS Program Descriptions

Program Category	IMIS Program Descriptions		
<i>Adult Basic Education</i>	Accounting Education Community Based Education Adult Basic Education/GED Prep Business Basics	Business Law Business Math Bus. Principles and Management Consumer Math Education- GED	GED- Community Based GED Keeping Financial Records for Bus. Literacy Volunteer Ed- Open Gate
<i>Health Education</i>	Open Gate Health- HIV C and T Pilot	HIV C and T Pilot Program	Pre-Release Infectious Disease Ed.
<i>Higher Education</i>	Higher Education- College Courses		
<i>Computer Training</i>	A+ Computer Repair Adobe Illustrator Adobe PageMaker Advanced Operating Systems Concepts and Applications	Corel WordPerfect Introduction to Computers Introduction to the Internet Keyboarding I Microsoft Excel	Microsoft Office Specialist Cert. Microsoft PowerPoint Microsoft Word Quicken Deluxe Windows Operating Systems
<i>Vocational Training</i>	3D Home Architect- Apprentice Apprentice Electrician Exam Prep. Aquaculture - AutoCAD LT97 AutoCAD LT97-Comp.Aided Drafting Automotive Technology Blueprint Reading - Building Building Construction	Carpentry- CLN Workplace CLN Workplace Safety-Food Service Electrical- Facility Maintenance Facility Maintenance- Horticulture Horticulture Vocational- Landscaping Landscaping- Metals Technology Metals Tech.- Mill and Cabinetry	Mill and Cabinetry- OSHA Standards OSHA Standards-Specialized Cert. OSHA Standards General Industry PreVocational Assessment Printing/Graphic Arts WV Welcome: Service Industry Underground Apprentice Mining
<i>Cognitive Skills</i>	Cog. Skills I: Thinking for a Change Cog. Skills II: Criminality	Cog. Skills III: Maintenance	Critical Thinking
<i>Coping Skills</i>	Assertiveness Training	Grief & Loss for the Female Offender	Incarceration Grief and Loss
<i>Life Skills</i>	Quality of Life Relationships	Relaxation Parole- Life Skills Training	Parenting
<i>Social Skills</i>	Cultural Diversity Empathy and Social Responsibility	Social Skills Emotion Management	Anger Management



Appendix E: Program Category and WDOC IMIS Program Descriptions (Continued)

Program Category	IMIS Program Descriptions		
<i>Transitional Services</i>	99 Days and a Get Up Life Going Home I Going Home II	Going Home III Job Search	Pre-Parole Orientation Pre-Par Orientation- Trans. Portfolio
<i>Domestic Violence P/I</i>	DV Intervention and Prevention Batterers Intervention	Transition Parole- Batterers Interv.	BIPP- Parole
<i>Sex Offender TX</i>	Sex Off. Tx. I: Psycho Education Sex Off. Tx. II: Cognitive Restructure	Sex Off. Tx. III: Relapse Prevention Sex Off. Tx. SA- A Woman's Way	Relapse Prev. Parole- Sex Off. Tx.
<i>Substance Abuse</i>	DUI Safety and Treatment Program NA Parole- Relapse Prevention A Woman's Way Twelve Steps AA Meetings- Community AA Meetings-Facility Cessation SA - DUI / DWI Flex	ALADRUE I ALADRUE II ALADRUE III Co-dependency for the Female Off. Group Substance Abuse Counseling DUI / DWI Flex Modules	Helping Women Recover NA meetings-Facility NA Meetings-Community Relapse Prevention RSAT Unit SA- Smoking
<i>Crime Victim Awareness</i>	Crime Victim Awareness		

ANNOTATED BIBILIOGRAPHY



GENERAL

1. **Authors:** Burns, P., Flaming, D., Haydamack, B.
Title: Homeless in L.A.: A Working Paper for the 10-Year Plan to End Homelessness in Los Angeles County
Source: Los Angeles, CA: Economic Roundtable, 2003.

According to the authors, Los Angeles' rate of homelessness is higher than the U.S. average because it has a higher rate of poverty and higher housing costs. In addition, the authors claim that of the total population that is homeless over the course of the year is predominately people who have short stints of homelessness. Thus, the authors conclude that the solution to homelessness lies in helping more people secure a sustainable income, and helping those who are unable to secure an income to obtain housing. Another striking finding of the report is that nearly 60% of homeless people that come into shelter care do so after having been in the care of another organization. Those most at risk of becoming homeless are those who have been in prison, jail, hospitals, domestic violence shelters, substance abuse programs, military service, and foster care. Thus, improper discharge is one part of the dynamics of homelessness. Here the authors suggest that post-release planning and advocacy would better reduce homelessness. These include, pre-release planning, transitional housing, enrollment in available benefits programs, and employment for most individuals.

2. **Authors:** Shinn, M., Baumohl, J.
Title: Rethinking the Prevention of Homelessness
Source: In Fosburg, L.B., Dennis, D.L. (eds.), Practical Lessons: The 1998 National Symposium on Homelessness Research. Delmar, NY: National Resource Center on Homelessness and Mental Illness, 1999. (Book Chapter: 34 pages)

In this essay, the authors examine existing measures to prevent homelessness. The logic and critical terminology of prevention is discussed. The authors also review research on the effectiveness of programs that aim to prevent homelessness. The authors conclude that most programs intended to prevent homelessness do useful things for needy people, but they seem to have only a marginal impact on the prevention of homelessness. They recommend that homelessness prevention be re-oriented from efforts to work with identified at-risk persons to projects aimed at increasing the supply of affordable housing, sustainable sources of livelihood, and the social capital of impoverished communities (authors). Available From: HUD USER, P.O. Box 23268, Washington, DC 20026, (800) 245-2691, www.huduser.org/publications/homeless/practical.html



3. **Authors:** Coalition for the Homeless of Louisville/Jefferson County, Kentucky.
Title: Reducing Homelessness: A Blueprint for the Future
Source: Louisville, KY: The Coalition for the Homeless of Louisville/Jefferson County, Kentucky, 2002. (Report: 14 pages)

This blue print is the result of a yearlong planning process, which involved city and county officials, community leaders and homeless service providers. The Blueprint consists of quality assurance standards for homeless service providers, guidelines for case managers and an advocacy agenda that target structural, personal, public policy causes of homelessness, as described by Dr. Martha Burt of the Urban Institute. Among the strategies that would help in ending homelessness in Louisville are promoting a living wage in the greater Louisville area and collecting data on the release of people into homelessness from state institutions (such as prisons, hospitals, mental institutions and the foster care system) and advocating for institutional after-care policies and programs.

4. **Authors:** Supportive Housing Network of New York.
Title: The Blueprint to End Homelessness in New York City
Source: New York, NY: Supportive Housing Network of New York, 2002. (Report 87 pages)

This blueprint provides concrete proposals designed to transform the City's current policies with the aim of reducing widespread homelessness in the city by half in five years, and ending it in ten. The Blueprint centers on the following key strategies: planning and coordination, permanent housing, prevention, and maximizing on the following key strategies: planning and coordination, permanent housing, prevention, and maximizing resources. In pursuing these strategies, the Blueprint recommends steps such as: developing a comprehensive plan to end homelessness with the full participation of City and State governments as well as non-governmental providers of shelter, housing and services; developing 16, 000 new units of supportive housing for individuals with a wide range of service needs and 3,000 new units for families; establishing an Interagency Discharge Planning Coordination Committee and holding government agencies accountable for release their clients into who have spent more than two years in the shelter system.

5. **Authors:** United States Interagency Council on Homelessness
Title: Good...to Better...to Great: Innovations in 10-Year Plans to End Chronic Homelessness in Your Community
Source: Washington DC: U.S. Interagency Council on Homelessness, 2005. (Report 24 pages)

This report focuses on the innovations and elements of a successful and effective 10-year plan. A major theme of the report is discipline. In order to successfully create and implement a 10-year plan there is a need for all parties involved to be disciplined in their commitment, thought, and actions. Good research and data are needed to move the response beyond anecdote to achievement of quantifiable results. It is also important that initial goals are achievable. The early successes will lend clout and legitimacy to the 10-year process and attract additional support and investment. Results-oriented discharge planning protocols from jails, substance abuse and mental health treatment facilities, foster care etc., should be thoroughly researched and implemented to ensure that resources are not being wasted and steps and actions of the plan are not being undermined. Business and corporations should be involved in the process as well and encouraged along by incentives and philanthropic giving.



6. **Authors:** J. Jenkins, S. Brinkman, P. Bather, K. Bratcher, T. Burch, L. Clark, P. Clark, J. Comer, R. Crimm, C. Hoffman, D. Horlander, M. Marzian, T. McKee, R. Meeks, C. Miller, S. Riggs, J. Wayne, R. Wilkey
Title: HB 376 An Act Relating to the Homeless Prevention Pilot Project
Source: Frankfort, KY: Kentucky Legislature, 2004

Directs the state to develop and implement a homelessness prevention pilot project that offers institutional discharge planning to persons exiting from state-operated or supervised institutions involving corrections, mental health, and foster care programs; direct the pilot project to be jointly supported by each of the cabinets, and provide for one office for the pilot project in a family resource center or department for Community Based Services. Provide that six months prior to the release of a person from a foster home, corrections facility, or mental health facility, a discharge coordinator for each such facility will contact the homeless prevention director for the county. Also discharge must be made to appropriate housing, including but not limited to a 24-month transitional program, supportive housing, or halfway house, and that discharge to an emergency shelter is not appropriate.

7. **Authors:** Hendrickson, S.
Title: Rapid Exit Program: Hennepin County, Minnesota
Source: Washington, D.C.: National Alliance to End Homelessness, 2001

The Rapid Exit Program is a program that facilitates rapid re-housing by relying on early identification and resolution of a family's or individuals "housing barriers" and providing the assistance necessary to facilitate their return to permanent housing. The program targets families and individuals who have moderate to severe barriers to obtaining market housing and are currently residing in the county funded shelter. The program provides direct financial assistance, case management, and assistance securing furniture and food.

8. **Authors:** Sullivan, Brian
Title: White House Interagency Council Announces New Strategy to Combat Chronic Homelessness
Source: Washington, DC: U.S. Interagency Council on Homelessness, 2002 (News Release 3 pages)

The comprehensive plan is collaboration between three federal agencies that would provide \$35 million in permanent housing and critical services to long term homeless individuals. The funding included \$20 million from HUD, \$10 million from HHS, and \$5 million from the VA. The new strategy was aimed at including a greater emphasis on prevention of individuals becoming homeless in the first place. The article sites that approximately 10 percent of the nations' homeless are chronically homeless – often suffering from mental illness or substance abuse. In addition, the administration announced the serious and Violent Offender Reentry Initiative. This \$100 million program identifies at-risk persons and prepares offenders for life outside prison and youth correctional facilities.



9. **Author:** National Alliance to End Homelessness
Title: New York City Department of Homeless Services Best Practice—Preventing Homelessness: Overview and Strategies
Source: Washington, DC: The National Alliance to End Homelessness, INC., 2005 (Report 3 Pages)

This article highlights some of the promising undertakings to prevent homelessness in New York City since Mayor Bloomberg launched the “Uniting for Solutions Beyond Shelter” plan in June 2004. The goal of this plan is to reduce homelessness by two-thirds within a five year period. Within the first year of the plans commencement the number of homeless individuals in shelters declined by 9 percent and the number of homeless children has declined by 13 percent. Research is woven into New York’s strategies and is used to “inform the development of the interventions and to evaluate the effectiveness of initiatives”. For example, data collection yielded information on families’ pathways to homelessness, lost opportunities for intervention, families at risk for re-entering shelters, and identified neighborhoods whose residents were most likely to become homeless. This information was used to refine interventions and target prevention services. The *Home Base Program* is designed to reduce new entrants to homelessness from the neighborhoods whose residents are at high-risk. The program provides financial assistance and services, such as job training and housing search assistance, and in its first nine months has seen a 14 percent decline in families entering shelters from the program. The *AfterCare Program* offers follow-up services to families who have exited shelters basing its efforts on research that found that “families who have recently exited shelter are highly vulnerable to returning to shelter” (cite). The *Housing Help Program* works to prevent the threat of eviction and stabilize families over to time to reduce the risk of homelessness in a high-risk neighborhood. Legal and social assistance is provided to families and one judge presides over eviction cases in the neighborhood. In the early days of the program the number of family evictions dropped to zero.

10. **Author:** National Alliance to End Homelessness
Title: New York City Department of Homeless Services Best Practice—Preventing Homelessness: HomeBase Program
Source: Washington, DC: The National Alliance to End Homelessness, INC., 2005 (Report 3 Pages)

The essential strategy of the HomeBase Program, run through the Department of Homeless Services, is to target resources to families teetering on the edge of homelessness within six neighborhoods. From there the DHS collaborates with neighborhood-based social service providers to meet the specific needs of target neighborhoods. Among the innovations of the program are the targeting demographic characteristics and locating geographic homeless “hotspots” within each community, regularly assessing how accurate each provider’s client base reflects the shelter entrant profile, and the generation of a street level map identifying the origin of each applicant.



11. **Author:** Malcolm Gladwell
Title: Million-Dollar Murray: Why problems like homelessness may be easier to solve than to manage
Source: New York, NY: New Yorker Magazine, 2006 (Periodical 12 pages)

The article makes the argument that homelessness is easier to solve than to manage. The author challenges the assumption that homelessness follows a common distribution like the bell curve and follows one more like the “power law distribution”—meaning, that most homeless people need relatively fewer services and case management to return to stabilized lives and permanent housing and that a few “hard cases” of chronically homeless are often more of a burden on the public benefit system homeless than housed in a supportive environment. Thus the author concludes, that is more efficient to solve the problem than to manage it. However, this assertion is not without its own challenges. The dilemma is, “Do we pool our resources into those most challenged few creating dependency to rebuild their lives or do we pool our resources on the majority that is in momentary crisis and create independence to rebuild their lives?”. The author asserts that, “we cannot do both”.

12. **Author:** Los Angeles Mission
Title: Homeless But Not Hopeless: Report on What Americans Believe About Homeless People, Their Problems, and Possible Solutions
Source: Los Angeles, CA: Gallup Survey, Los Angeles Mission. 1995

The American Public believes that the average homeless person is a single male between the ages of 18 and 55. In addition, most Americans believe that homelessness is caused by a lack of employment, lack of affordable housing, and alcohol and substance abuse. Interestingly, of those surveyed primarily women and persons below the age of 35 had increased sympathy towards the homeless because of the realization that they could on day become homeless. Most Americans also believe that private charities are the solution to the problem of homelessness.

13. **Author:** Burt, Martha R.
Title: What Will It Take to End Homelessness?
Source: Washington, D.C.: Urban Institute, 2001

On any given night in the U.S. 800,000 people experience homelessness. Homelessness is a condition created by desperate poverty and lack of affordable housing. During the past 20 years the U.S. has experienced a contraction in affordable housing and safety-net programs thus leaving the most vulnerably housed in a precarious situation. The author argues that in order to end homelessness society must be committed to; 1) rebuilding communities, especially troubled ones, 2) build more housing and subsidize the cost to make it affordable to people with incomes below the poverty level, 3) help more people afford housing, by providing them with better schools, better training, and better jobs, and 4) prevent the next generation of children from experiencing homelessness.



14. **Author:** Institute for the Study of Homelessness and Poverty
Title: Homelessness in Los Angeles: A Summary of Recent Research
Source: Los Angeles, CA: Institute for the Study of Homelessness and Poverty, 2004

Widespread homelessness in times of economic prosperity is a relatively recent occurrence and national response to the “new homeless” is focused on local services rather than public policy actions. Los Angeles has been found that higher rates of homelessness than the nation as a whole. Also, most homeless families and individuals are concentrated in central and south Los Angeles. In the case of families they are usually headed by single mother and represent a growing percentage of the overall homeless. In addition, one-third to one-half of homeless people are women and girls. African Americans are greatly over-represented within the homeless population and most homeless people are in Los Angeles are from Los Angeles. Homeless people have very low income and contrary to what many people believe 16%-20% of homeless adults are currently employed. In relation, public benefits are underutilized or have been cut for many homeless families and individuals.

15. **Authors:** Semansky, R., Quinn, L., Azrin, S., Noftsinger, R., Moran, G., Koenig, T.
Title: Evaluability Assessment of Discharge Planning and the Prevention of Homelessness, Final Report
Source: Rockville, MD: Westat, 2005

This study is an evaluability assessment to determine whether the effectiveness of discharge planning to prevent subsequent homelessness can be evaluated in four particular setting: inpatient psychiatric treatment; residential treatment centers for children and youth; residential programs for substance use disorders; foster care. People with substance abuse exiting institutional facilities such as detoxification and/or treatment programs, youth and adults with mental illnesses and/or substance use disorders released from inpatient treatment or residential settings, and young people aging out of foster care and state social services are all at risk of becoming homeless.

16. **Authors:** Wolch, J., Dear, M., Tepper, P., Blasi, G., Flaming, D., Koegel, P.
Title: Ending Homelessness in Los Angeles
Source: Los Angeles, CA: Inter-University Consortium Against Homelessness, 2007

The report argues that it should be possible to find the resources needed to end homelessness. In 2005, the city of Los Angeles spent less than \$1 per capita to address homelessness, (compared to \$3 in Chicago, \$8 in Boston, and \$13 in Seattle). In L.A. County overall, local jurisdictions using local, state, and federal funds as well as private sources spend about \$600 million annually. The annual cost of sheltering and sustaining every homeless person in Los Angeles County could be approximately \$1.5 billion. New York City spends \$1.7 billion each year on services and housing for its much smaller homeless population, driven in part by the realization that not providing supportive housing and services to homeless people is expensive. The rapid construction of affordable and supportive housing there has reduced the homeless population to such an extent that the city's largest shelter, with 1,000 beds, will be closed in June. Los Angeles should take a similar approach to ending homelessness and its human and financial toll.



17. **Authors:** Interagency Council on the Homeless
Title: Exemplary Practices in Discharge Planning: Working Conference on Discharge Planning Report and Recommendations
Source: Washington, DC: Interagency Council on the Homeless, 1997. (Report: 19 pages)

The Interagency Council on the Homeless convened a Working Conference on Discharge Planning in June 1997 to identify and build consensus for the key elements of effective discharge planning and to develop recommendations for exemplary discharge planning practice. The statements and recommendations in this report represent the consensus of the Working Conference. They are organized in five categories: roles and responsibilities; elements of an effective discharge plan; collaboration and partnerships; and funding and cost issues. This report is intended to assist states, institutions and facilities, local communities, and the Department of Veteran Affairs to develop and implement effective discharge planning systems and practices.

18. **Authors:** Lindblom, E.N.
Title: Toward a Comprehensive Homeless-Prevention Strategy
Source: Housing Policy Debate 2(3):957-1025, 1991

The author cites one New York study and two Chicago studies (p.965) that surveyed homeless persons and found that none have been in foster care, jail, a state hospital, or any other kind of institution **immediately before** becoming homeless. These studies suggest that for those who ultimately become homeless, discharge from institutional living is an early step towards homelessness but not a direct cause. There is usually some period of intermediate housing. Few people go directly from institutions to the streets. There is no evidence that substantial number of youths age out of foster care with no place to go. Author states a need for a macro level effort to prevent homelessness. Expanded prevention efforts will only increase the demand for scarce resources. Increasing availability of resources will not only provided a more supportive environment for targeted prevention interventions but will also ultimately reduce the need for interventions by simultaneously attacking the root causes of homelessness – poverty, illness,



19. **Authors:** Kadushin, G., Kulys, R.
Title: Discharge Planning Revisited: What Do Social Workers Actually do in Discharge Planning?
Source: Social Work 38(6): 713-726, 1993. (Journal Article: 13 pages)

This article discusses whether discharge planning has a primarily focus on the provision of concrete services, counseling, or both. The authors asserts that, within a structured interview format, eighty social workers in thirty-six acute care hospitals were asked to estimate the amount of time they spent on and the importance of seventy-three discharge planning tasks. The article states that respondents were also asked to locate themselves on an activity continuum. The survey **results are discussed in terms of the prospective payment system's emphasis on expeditious discharge and the challenge to social workers in enabling patients and families to have some control over decision making in this climate** (authors).

Discharge planning in hospitals is still performed primarily by social workers (cited 1990 source). Cost containment measures enacted since 1983 have propelled discharge planning into a central role in the hospital, enhancing the importance and prestige of discharge planners. With the exception of two studies completed more than 20 years ago, there is little empirical research on discharge planning. This study sought to find out from social workers engaged in discharge planning what they actually do and how they relate in importance to carrying out their jobs as discharge planners. (adapted from article). The study was designed to answer three questions: 1)How much time do social workers spend performing specific discharge planning tasks? 2)How important are these tasks to accomplishing the objectives of discharge planning? 3) Where do these tasks belong on the discharge planning continuum?

20. **Authors:** Belcher, J.R., DeForge, B.R., Zanis, D.A.
Title: Why Has the Social Work Profession Lost Sight of How to End Homelessness?
Source: Journal of Progressive Human Services 16(2): 5-23, 2005

In this article, the authors note that many academic research studies are government funded and thus the research draws conclusions that will generally not require systemic changes in society. Social activists are silenced in favor of academics that define social problems narrowly. Academic journals expect authors to write in a scientific value neutral manner and ideas that might challenge the system are encouraged to be left behind. **Government agencies tend to focus research on the homeless mentally ill or substance abusers, never mind that two thirds of homeless people are not severely mentally ill and/or addicted.** Due to that, findings that homeless people suffer from poverty are largely overshadowed. That homeless population rarely makes it on the agenda of the federal government. The authors argue that social workers have several important roles – 1)insure accountability for how funds are utilizes in our communities; 2)to become active members of housing authorities and engage in community planning efforts; 3) to advocate for individuals who are homeless, regardless of their pathways to homelessness. Too much focus on disabling conditions of homeless people and disregard for homelessness as a result of poverty. Social work researchers must realize that homelessness will not be addressed as a social problem until we as a society begin to admit that capitalism creates winners and losers (i.e., homeless people).



21. **Authors:** Shinn, M., Baumohl, J.
Title: Rethinking the Prevention of Homelessness
Source: In Fosburg, L.B., Dennis, D.L. (eds.), Practical Lessons: The 1998 National Symposium on Homelessness Research. Delmar, NY: National Resource Center on Homelessness and Mental Illness, 1999. (Book Chapter: 34 pages)

In this essay, the authors examine existing measures to prevent homelessness. The logic and critical terminology of prevention is discussed. The authors also review research on the effectiveness of programs that aim to prevent homelessness. **The authors conclude that most programs intended to prevent homelessness do useful things for needy people, but they seem to have only a marginal impact on the prevention of homelessness.** They recommend that homelessness prevention be re-oriented from efforts to work with identified at-risk persons to **projects aimed at increasing the supply of affordable housing, sustainable sources of livelihood, and the social capital of impoverished communities** (authors). Available From: HUD USER, P.O. Box 23268, Washington, DC 20026, (800) 245-2691, www.huduser.org/publications/homeless/practical.html

22. **Authors:** Rodriguez, L.
Title: Discharge Planning Safety Considerations: Safety Considerations that Impact an Individual Wishing to Live in the Community
Sources: Los Angeles, CA: Homeless Health Care Los Angeles; Homelessness: An Overview and Effective Strategies for Discharge Planning of Homeless Patients, 2006

A listing of issues is provided that should be reviewed as part of a discharge plan to identify patient safety concerns. These issues are: individual capacity issues such as sensory deficits; environmental issues such as unsafe housing and lack of support; and provisions of service issues such as lack of transportation and insurance coverage. Policy and process elements are listed as key elements for effective and safe discharge planning to facilitate an individual's right to choose. Clear policies, protocols and standards, early planning and intervention, privacy standards, a resource database, coalition building with resources, realistic service plans, available care management, and patient education are part of the policy component of a discharge plan. A discharge plan process should include person-centered assessment, communication and coordination among caregivers and stakeholders, support from a multi-disciplinary team, collaboration with advocates, and peer support.



23. **Authors:** Rodriguez, L.
Title: What the Discharge Planner Needs to Know in Order to Effect a Safe and Efficient Transition
Sources: Los Angeles, CA: Homelessness: An Overview and Effective Strategies for Discharge Planning of Homeless Patients, 2006

A list of questions a discharge planner should review when working with an individual as part of a discharge plan. A discharge planner should be aware of a person's baseline information such as their medical and psychological status and their support systems. Medical providers and prior service utilization should be identified. Expectations of the medical team, client, and supports should be identified. Identification, assessment, and education of who will be providing post-discharge care is also listed. Available resources and environmental limitations of patient's residence are also important.

24. **Authors:** Grimmer, K., Moss, J., Falco, J., Kindness, H.
Title: Incorporating Patient and Career Concerns in Discharge Plans: The Development of a Practical Patient-Centered Checklist
Sources: The Internet Journal of Allied Health Sciences and Practice 4(1), Jan 2006

The authors have outlined the development of a patient-centered checklist generated from patient and career concerns related to being prepared for discharge. The authors believe that discharge plans should include prompts for patients and their families to identify key concerns regarding daily life after discharge from a hospital. A six-month series of post-discharge interviews of elderly recently ill patients and their careers identified concerns relating to transport home, entry into the home, having food and effective heating and cooling systems, obtaining assistance in managing home and family responsibilities, navigating in home, accessing their doctor, shopping, paying bills, and regaining social contacts. Discharge planning is defined as the systematic identification and organization of services and supports to assist patients to manage in the community post-discharge.

25. **Authors:** Grimmer, K., Dryden, L., Puntumetakul, R., Young, A., Guerin, M., Deenadayalan, Y., Moss, J.
Title: Incorporating Patient Concerns into Discharge Plans: Evaluation of a Patient-Generated Checklist
Sources: The Internet Journal of Allied Health Sciences and Practice 4(2), Apr 2006

The effectiveness of a checklist that assists in discharge planning is reviewed in three public hospitals with elderly clients over the age of 60. The checklist focused on issues associated with a return home after a hospital stay such as safe transportation, caring for others at home, community services, understanding medication, safety and health at the home, and managing duties at home. 89% of subjects considered the checklist relevant to them and/or others; 81% felt that the checklist made them aware of issues that they might not have otherwise considered. The checklist was also seen as a useful tool for discussion with family and friends. It was suggested that the checklist be provided at hospital entry to families and patients for the best preparation.



26. **Authors:** Sommers, P., Mauldin, B., Levin, S.
Title: Pioneer Human Services: A Case Study
Sources: University of Washington, Seattle, WA, January 2000

Pioneer Human Services (PHS) is a large entrepreneurial nonprofit organization based in Seattle, Washington that provides opportunities for current and former prisoners, recovering addicts, and others to improve personal, economic, and social development. PHS serves 6,500 clients per year and 2,500 per day. PHS offers education, employment, housing, and counseling services to clients so that they learn basic skills and have a successful reintegration into society. PHS employment programs include the Food Operations program which involves operation of a retail food business; Pioneer Construction Services which provides services for PHS properties and third-party contracts; Pioneer Distribution services provide packaging and warehouse services for contract businesses; Pioneer Industries operates two manufacturing plants that specialize in producing cargo liners for Boeing and products for other customers; and Pioneer Consulting Services that consults with nonprofit agencies, foundations, and other agencies in the areas of social enterprise and measuring program outcomes. Pioneer Counseling Services provides substance abuse treatment and counseling services. PHS also has various residential treatment/recovery centers, transitional housing, and permanent economy housing. PHS is almost entirely funded through profits generated from its businesses. (from summary handout)

Major conclusions of the case study of PHS are as follows: PHS is an excellent example of a non-profit using a business model while operating programs in such a way that best prepare clients for employability and self-sufficiency; PHS has created a self-sustaining employment base for the clients and has helped many successfully enter the labor force; PHS' long-standing business relationship with Boeing has enabled it to launch new business ventures and grow; ex-felons who participated in Pioneer work release had somewhat better outcomes in terms of criminal recidivism, hours worked after leaving training, and hourly wages earned; and focus groups found that PHS could offer more support to workers in problem resolution with respect to personal issues and assist workers in finding work outside of Pioneer if they choose to leave. The study suggests that ex-felons and former drug abusers can change their lives if they decide and that training, services, and support are critical to a successful transition into society; although challenging, non-profits can use a business model and still serve clients; and customers of an entrepreneurial non-profit can be key partners in realizing social service goals.



27. **Authors:** Culhane, D., Metraux, J., Hadley, T.
Title: The Impact of Supportive Housing on Services Use for Homeless Persons with Mental Illness in New York City
Sources: Center for Mental Health Policy and Services Research, University of Pennsylvania, 2000

A review of the NY/NY Housing Agreement to House the Homeless Mentally Ill of 1990 (NY/NY) was conducted. NY/NY was an agreement between the state and city of New York to fund the development and maintenance of 3,600 supportive housing units. Services are provided for those who have a serious mental illness diagnosis and a record of homelessness. Data for the study was available on 4,679 NY/NY placement records between 1989 and 1997. The study focused on how housing placements affected use of city shelters, state psychiatric hospitals, state Medicaid services, city hospitals, Veterans Administration hospitals, state prisons, and city jails. The study found that homeless mentally ill are high service utilizers costing \$40, 449 per person per year and providing NY/NY services reduced associated costs by 30%; and 95% of supportive housing costs were offset by service reductions. The study underestimated savings associated with program-funded services and crime and did not quantify benefits to consumers. The authors stated that NY/NY was a sound public investment.

28. **Author:** Cousineau, M., Nocella, K., Cross, T., Jefferson, M-E.
Title: Neglect on the Streets: The Health and Mental Health Status and Access to Care for Homeless Adults and Children in Central Los Angeles
Source: Los Angeles, CA: USC, 2003

The purpose of the report is to provide an update on the health and mental health needs of the homeless in Los Angeles, assess the current health care delivery system available to the homeless, and to identify barriers to care that currently exist. The report found that homeless people of higher rates of mental health problems and substance abuse problems. In addition homeless children have higher rates of developmental delays and learning disabilities. There is not enough capacity to meet the medical needs of the community and the system of care is fragmented. Because of these conditions the authors recommend a different approach than the current that 1) increases outreach services, 2) expands the primary health care services, 3) expands the primary health care for those in skid row to surrounding areas, 4) assures needed primary care for families through existing family clinics, and 5) chronic disease detection, treatment, and management. In addition, the authors envision an integrated delivery system established by a coordinating body for health in the Central Los Angeles area. Thus, the authors emphasize system coordination, quality assurance, and advocacy as methods to improve the system of care to homeless patients and their families.



29. **Authors:** Chalmers, G.
Title: Listing of 'Homeless Initiatives'
Sources: Massachusetts Behavioral Health Partnership, 2002

This document is a listing of homeless initiative that the Massachusetts Behavioral Health Partnership (MBHP) has managed from Fiscal Year 1999 to Fiscal Year 2002. The "Homelessness" initiative focused on collaborating "with the homeless advocate community to identify strategies and resources appropriate psychiatric discharge dispositions for homeless adults who are enrolled in" specified health care services. The "Homeless-Discharge Planning" initiative was an expansion of the "Homeless" initiative to mental health providers in different regional areas. Another key initiative was a collaborative effort with homeless advocacy and health care providers to create a website containing aftercare planning best practices, developed specifically for providers of services to homeless members. MBHP also worked to strengthen discharge planning protocols for hospitals serving the homeless and those at risk of being homeless through support of efforts to facilitate transfer to supported housing and other community-based resources. In addition, an initiative was created to increase access to behavioral health services for families living in hotels/motels funded through the Department of Transitional Assistance. All initiatives were implemented by contractors and used collaboration as a tool.

30. **Authors:** Shelter Partnership, Inc., Lamp Community, OPCC, RAND ??Houghton, T.
Title: Ending Chronic Homelessness Among People with Mental Illness: The Community Model

This manual is an information guide for service providers and policymakers on how to incorporate the Community Model into programs for chronically homeless people. The Community Model was developed by LAMP Community in Los Angeles over the past two decades. This model **"is a comprehensive method of service provision that has helped thousands of homeless people with mental illness achieve residential stability and an improved quality of life. Employing harm reduction service strategies in a safe, flexible and non-hierarchical environment, the Community Model allows people to tailor their own paths to recovery and wellbeing"** (cite). The model has been effective at serving those who are difficult-to-engage namely the dually-diagnosed and other members of the chronically homeless population. The model is driven by the principles of harm reduction where the focus is on improvement of quality of life and the gradual reduction of the negative consequences of drug use and mental illness; and by community building where members are encouraged to explore their own strengths and how they can contribute to the community. The model also provides housing, service, and support components. A primary goal of the model is to first end a client's homelessness and provide residential stability. According to the model, once stabilized in housing, other positive outcomes such as decrease in psychiatric instability and substance use will follow.

The Commonwealth of Massachusetts, Executive Office for Administration and Finance. *Policy Report Excerpts: Moving Beyond Serving the Homeless to Preventing Homelessness*. Policy Report Series No. 5, October 2000.
www.magnet.state.ma.us/eoaf

Supportive Housing Network of New York. *The Blueprint to End Homelessness in New York City*. June 2002.
www.shnny.org



MENTAL HEALTH AND SUBSTANCE ABUSE

- 1. Authors:** Substance Abuse and Mental Health Services Administration
Title: Blueprint for Change: Ending Chronic Homelessness for Persons with Serious Mental Illness and Co-Occurring Substance Use Disorders
Source: DHHS Pub. No. SMA-04-3870, Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2003 (Report: 123 pages)

SAMHSA developed this Blueprint for Change to disseminate information about ending chronic homelessness for people who have serious mental illnesses and co-occurring substance use disorders. This report does not cover substance users who do not have a co-occurring mental illness. The document reviews past and current research and offers practical advice on how to organize an integrated system of care to end homelessness for this population. Nearly half of persons who are homeless have substance use disorders. It includes chapters that describe the current state of community based treatment for this group, characteristics of this group, value and principles of change, etc.

- 2. Authors:** Lezak, A.D., Edgar, E.
Title: Preventing Homelessness Among People with Serious Mental Illnesses: A Guide for States
Source: Rockville, MD: Center for Mental Health Services, 1998. (Report: 50 pages)

This paper has three objectives: to demonstrate the need for prevention-oriented approaches to end homelessness among people who have serious mental illnesses; to make recommendations regarding state-level strategies to strengthen prevention efforts; and to give examples of specific state-supported initiatives and local efforts that are assisting people who have a serious mental illness to avoid homelessness. Many of these state and local initiatives **serve to expand the reach of federal homelessness assistance programs**. The report is designed primarily for those involved in planning and administering mental health programs and services for homeless people (authors).

- 3. Authors:** Walker, S.A. and Eagles, J.M.
Title: Discharging Psychiatric Patients from Hospital
Source: Psychiatric Bulletin 26:241-242, 2002 (2 pages)

The authors argue in this editorial that in the period following discharge from hospital, psychiatric patients are at a high risk of readmission. Often, there is poor communication at the time of discharge between healthcare professionals – hospital specialist and the general practitioners that patients are discharged to. One study they cited in the article, found that after discharge, 90% of elderly patients were receiving different medication regimes at home than what they had been prescribed at the hospital. While they cite another study that found that pre-discharge visits improved collaboration between the general practitioner and the hospital, the authors doubt that this would transfer cost-effectively to psychiatric settings. They conclude that there is no good evidence to improve the situation for psychiatric patients post-discharge and therefore, more research needs to be done before policies are put in place to address this situation.



- 4. Authors:** New York State Assembly Standing Committee on Mental Health, Mental Retardation, and Developmental Disabilities
Title: Public Hearing on Discharge Planning for the Mentally Ill, October 18, 1996
Source: Brooklyn, New York: EN-DE Reporting Services, 1996 (Testimony: 450 pages)

This is the testimony of a public hearing on discharge planning for the Mentally Ill in New York State, convened by the State Assembly Standing Committee on Mental Health, Mental Retardation, and Developmental Disabilities. The hearing attempts to address the many problems faced by mentally ill persons who are discharged into the community with a lack of support from a fragmented service system. These problems include: the widespread homelessness in New York City, the lack of adequate services for patients and their families, and the lack of housing. The panel discusses these issues with a group of 32 witnesses, including administrators from the New York State Office of Mental Health, as well as clinicians, educators, and advocates.

Dr. Noah Taylor, Beth Israel Hospital: NYNY agreement defines homelessness in a fairly narrow way, it's difficult for many homeless to produce documentation that they are indeed homeless. Some outpatient clinics that we refer to refuse certain types of patients. Some patients become homeless upon admission so they are homeless after the fact but they don't meet the NYNY criteria for homelessness. Many outpatient community resources will not accept a patient until you have documentation that they in fact are going to have these services so that institution can be paid.

- 5. Authors:** Christ, W., Clarkin, J., Hull, J.
Title: A High-Risk Screen for Psychiatric Discharge Planning
Source: Health and Social Work 19(4): 261-270, 1994 (Journal Article: 10 pages)

This article tests the hypothesis that psychiatric inpatients at high risk for presenting difficulties in aftercare planning can be accurately identified on admission to an inpatient unit. According to the authors, 66% of the patients rated high risk at admission were identically rated at discharge. The article states that differences among risk groups were also found with respect to key demographic variables, and that the high risk screen permits early identification of patients who will require immediate and intensive environmental interventions. The authors assert that such data is critical to psychiatric social work in preventing overstay and in deploying department resources with maximum effectiveness (authors).

They developed and tested using a high-risk indicator instrument. Some high scoring items were non-adherence, and interestingly, discharge against medical advice were viewed as causing less difficulty for discharge planners. The high-risk assessment instrument is also intended to serve as a risk-management tool so that the highest level of expertise in the social work department can assist with those cases that pose the greatest threat of liability to the hospital. The high-risk screen does help identify those that may be most difficult to plan for aftercare services.



- 6. Authors:** Gantt, A., Cohen, M., Sainz, A.
Title: Impediments to the Discharge Planning Effort for Psychiatric Inpatients
Source: Social Work in Health Care 29(1): 1-14, 1999 (Journal Article: 14 pages)

This study investigates a methodology to systematically track the effort to overcome impediments to securing needed post-hospital care and support. The authors state that 494 consecutive admissions to the Mount Sinai Medical Center were evaluated for the quality of available support resources in the domains of housing, daily activity, and psychiatric treatment using the Mount Sinai Discharge Planning Inventory. The authors assert that having an impediment in any of the three resource categories (housing, daily activities, psychiatric treatment services) at day seven was predictive of a sub-optimal discharge plan, and that of all three resource categories studied, a decline in overall impediments from day seven to discharge was significant only for psychiatric treatment services. The article also states that an internal/clinical impediment in any of the three resource categories on day seven was associated with a patient history of alcohol and drug abuse, and a significant association was found between having external/environmental impediments identified at discharge for housing and psychiatric treatment services with return to the hospital within 90 days of discharge. The authors conclude that the study of the impediments to the discharge planning effort provides an opportunity to elucidate the factors that comprise the pathway of recovery from psychiatric illness, but which are normally ill-defined, poorly understood, or not readily measured (authors).

- 7. Authors:** Lamb, H.R., Bachrach, L.
Title: Some Perspectives on Deinstitutionalization
Source: Psychiatric Services 52(8):1039-1045, 2001 (Journal Article: 7 pages)

In this article, the authors discuss what can be learned from our experience with deinstitutionalization. The deinstitutionalization of mentally ill persons has three components: the release of these individuals from hospitals into the community, their diversion from hospital admission, and the development of alternative community services. The greatest problems have been in creating adequate and accessible community resources. Where community services have been available and comprehensive, most persons with severe mental illness have significantly benefited. On the other hand, there have been unintended consequences of deinstitutionalization -- a new generation of un-institutionalized persons who have severe mental illness, who are homeless, or who have been criminalized and who present significant challenges to service systems. Among the lessons learned from deinstitutionalization are that successful deinstitutionalization involves more than simply changing the locus of care; that service planning must be tailored to the needs of each individual; that hospital care must be available for those who need it; that services must be culturally relevant; that severely mentally ill persons must be involved in their service planning; that service systems must not be restricted by preconceived ideology; and that continuity of care must be achieved (authors).



8. **Authors:** Wright, J.D., Rubin, B.A.
Title: Is Homelessness a Housing Problem?
Source: Housing Policy Debate 2(3): 937-956, 1991. (Journal Article: 20 pages)

Homeless people exhibit high levels of mental illness and substance abuse, extreme degrees of social estrangement, and deep poverty. Each of these conditions poses unique housing problems, which are discussed in this article. In the 1980s, the number of poor people has increased and the supply of low-income housing has dwindled; these trends provide the background against which the homelessness problem has unfolded. The authors discuss the characteristics that contribute to the housing problems of mentally disturbed homeless persons and they suggest that adequate supported transitional and extended-care housing would be sufficient to address their housing needs.

9. **Authors:** Steinberg, D.
Title: AB 2034 Integrated Services for Homeless Mentally Ill
Sources: California Legislature, 2000 & AB 2034 Impact Statement January 2007

Assembly Bill 2034 is the expansion of AB 34 pilot program in 1999. AB 34 addressed the longstanding problem of the under funded community mental health care system and the consequences of severely mentally ill adults not getting treatment resulting in these adults being homeless, incarcerated in jails, and hospitalized. The pilot program was established in Los Angeles, Sacramento, and Stanislaus counties to provide extended community mental health services and outreach to mentally ill adults who are homeless or at risk of homelessness. The success of AB 34 in stabilizing and treatment of more than 1,000 people supported AB2034's request to permit additional counties that had or could develop adult system of care programs to have an opportunity to participate in these programs, based upon unmet needs, successful existing programs, and each county's capacity to increase services as well as allow the three pilot counties to continue expansion of programs based upon unmet need.

Funding increased from \$10 million to \$55 million to increase intensive community-based services for those who are mentally-ill, homeless, and who have a history of incarceration or are at high-risk of being incarcerated. Los Angeles County received \$18.25 million to expand services and treat more clients through an increase in contracted agencies.

Features of AB2034 are a low staff-to-client ratio, cultural competence, 24/7 staff availability, community-based services, housing and employment services, a focus on harm reduction, and collaboration with community agencies and members to better advocate and serve clients. AB 2034 was created to have measurable outcomes and some important findings are that there is a: 82% reduction in the number of clients homeless; 70% reduction in the number of days clients were homeless; 17% reduction in hospitalizations; 66% reduction in number of days hospitalized; 67% reduction in the number of incarcerations; 82% reduction in the days of incarceration; 164% increase in the numbers of consumers receiving SSI/SSDI. Based on the May 2006 reporting period 55% of clients lived independently in their own apartment; 17% were employed in paid positions; 11% worked more than 20 hours/week; and 8% attended school. AB 2034 is successful as an alternative method to treating and supporting clients who are difficult to engage and are on the fringe of society. The "whatever it takes" mentality is part of the programs success.



- 10. Authors:** Culhane, D., Metraux, J., Hadley, T.
Title: The Impact of Supportive Housing on Services Use for Homeless Persons with Mental Illness in New York City
Sources: Center for Mental Health Policy and Services Research, University of Pennsylvania, 2000

A review of the NY/NY Housing Agreement to House the Homeless Mentally Ill of 1990 (NY/NY) was conducted. NY/NY was an agreement between the state and city of New York to fund the development and maintenance of 3,600 supportive housing units. Services are provided for those who have a serious mental illness diagnosis and a record of homelessness. Data for the study was available on 4,679 NY/NY placement records between 1989 and 1997. The study focused on how housing placements affected use of city shelters, state psychiatric hospitals, state Medicaid services, city hospitals, Veterans Administration hospitals, state prisons, and city jails. The study found that homeless mentally ill are high service utilizers costing \$40, 449 per person per year and providing NY/NY services reduced associated costs by 30%; and 95% of supportive housing costs were offset by service reductions. The study underestimated savings associated with program-funded services and crime and did not quantify benefits to consumers. The authors stated that NY/NY was a sound public investment.

- 11. Authors:** Roth, L.S.
Title: Discharging the Un-dischargeable Patient
Sources: Practitioner Forum: Federal Practitioner, March 2006

This article establishes a set of rules and responses psychiatrists and their treatment team colleagues can follow when faced with differentiating between an inappropriate (or inappropriately extended) admission from the irresponsible of a potentially suicidal or homicidal patient (author). The rules are as follows 1) Do not second-guess a suicidal patient, admit him or postpone his discharge; 2) For unavoidable off-grounds passes, have the patient sign a no-relapse contract; 3) No cash for transportation; 4) Responsibility for getting well belongs with the client; 5) Help the patient put things in proper perspective; 6) Empathize, but challenge; 7) Break the cycle of the blame game; 8) Be positive and sincere; 9) Substance abuse by any other name is still substance abuse; and 10) No double-binding staff - client stating that they 'feel safe' in the hospital but will be suicidal if discharged (authors). Each of these rules is coupled with real-life responses that staff can use when assessing and treating clients.



12. Authors: D.S.

Title: Predictors and Outcome of Discharge Against Medical Advice From the Psychiatric Units of a General Hospital

Sources: Psychiatric Service 49(9), September 1998

This study examined predictors of discharge against medical advice (AMA) and outcomes of psychiatric patients with AMA discharges, as measured by poorer symptoms ratings at discharge and higher rates of re-hospitalization (authors). 195 patients discharged from hospital psychiatric units were compared retrospectively with 2,230 regularly discharged patients. Six significant predictors for AMA discharge were use of a large quantity of substances, more than two previous inpatient admissions, ethnicity other than Caucasian, absence of functional impairment due to medical illness, male gender, and mild or no suicidal ideation at admission. AMA patients have significantly worse outcomes at discharge, higher scores on the Psychiatric Symptom Assessment Scale, greater suicidality, more anxiety and hostility-aggression, were more uncooperative and had poorer insight into their illness than patients regularly discharged (authors). Client at risk of being AMA discharged must be identified early so that discharge planning can begin early. It is also suggested that transition to outpatient treatment be facilitated regardless of discharge status. Pages, K., Russo, J.E., Wingerson, D. K., Ries, R.K., Roy-Byrne, P.P., Cowley,

13. Authors: Podymow, T., Turnbull, J., Coyle, D., Yetisir, E., Wells, G.

Title: Shelter-based managed alcohol administration to chronically homeless people addicted to alcohol

Sources: CMAJ 174(1), January 2006

This study recorded the results of providing supportive shelter to seventeen chronically homeless adults (average age 51) with alcoholism in a Managed Alcohol Project (MAP). MAP is part of a harm reduction approach – a policy to reduce the adverse health, social, and economic consequences of substance use without requiring abstinence. While in the program, participants were given alcohol on an hourly basis. It was found that police encounters decreased by 51% and emergency department visits decreased by 36%. Participants reported decreased alcohol use while in the program, blood-test markers remained stable, and participants and staff reported improvements in health, nutrition, and hygiene. Compliance with taking prescribed medication and appointment attendance was better than compared with predicted outcomes for alcoholic individuals who are homeless. The authors stated that those responsible for the well-being of homeless people should consider the implementation and prospective evaluation of programs that integrate health services within shelters using a harm-reduction strategy (authors).



- 14. Authors:** Massachusetts Behavioral Health Partnership
Title: Discharge Planning for Adults Who are Homeless. Treatment Improvement Series 1
Source: Boston, MA: The Massachusetts Behavioral Health Partnership, 2000 (Manual: 7 pages)

This Improvement Series is offered in response to, and in support of initiatives begun to increase awareness of and improve discharge planning for people who are homeless who are receiving care in acute settings (inpatient, detox, and crisis stabilization programs). The Partnership has developed the Treatment Improvement

Series to ensure that the mental health and substance abuse treatment available through the Partnership's provider network is of the highest quality and optimally responsive to high risk members. The Improvement Series is designed to educate providers regarding improvement protocols, to articulate expectations regarding

staff training, and to review treatment improvement monitoring systems (authors). Available From: The Massachusetts Behavioral Health Partnership, 150 Federal Street, 3rd Floor, Boston, MA 02110, (800) 495-0086, www.masspartnership.com.

- 15. Authors:** Rickards, L.D., Ross, E.C.
Title: Report on State Hospital Discharge Planning Policies, Procedures, and Practices and Proceedings of the Discharge Planning Workshop
Source: Rockville, MD: Center for Mental Health Services, 1993 (Report: 35 pages)

This report reviews a project in which the purpose was to improve discharge planning and aftercare for seriously mentally ill adults and people who are homeless. The study concluded that most state hospitals had thorough discharge planning processes - with treatment plans that included discharge arrangements, input from professional staff, involvement of community mental health and other community service staff, and

involvement of patient and family. Several facilities in the study were aware of weaknesses in their discharge planning procedures. Other hospitals had minimal discharge plans, with an orientation towards custodial care rather than community rehabilitation or integration. Many of these latter facilities reported very weak links

with the community service system. Also included is a summary of the workshop convened to review and comment on the report. The workshop discussion focused on three main areas: the analysis of state mental hospital discharge planning, barriers and facilitators to implementing a discharge plan, and strategies for improvement (authors).

- 16. Authors:** Olfson, M., Walkup, J.
Title: Discharge Planning in Psychiatric Units in General Hospitals
Source: New Directions for Mental Health Services (73): 75-85, 1997. (Journal Article: 10 pages)

This article discusses the potential for a better-integrated system of care for vulnerable patients when increased attention is paid to discharge planning. Discharge planners face the formidable challenge of linking severely ill psychiatric inpatients to a range of community services in a timely and clinically appropriate manner. Longitudinal research indicates that the skill with which this work is performed influences patient outcomes.

Patients who receive adequate discharge planning are more likely to utilize outpatient mental health services, less likely to become socially.



- 17. Authors:** Rosenheck, R. A., Dennis, D.
Title: Time-limited Assertive Community Treatment for Homeless Persons with Severe Mental Illness
Source: Arch Gen Psychiatry 58: 1073- 1080, 2001

This study examined changes in health status and service utilization of homeless mentally ill clients after discharge or transfer from the assertive community treatment (ACT) model. 1617 participants from the Access to Community Care and Effective Services and Supports (ACCESS) program agreed to be assessed at entry into ACT, 3, 12, and 18 months later. This study suggests that homeless clients who have severe mental illness can be selectively discharged or transferred from ACT without subsequent loss of gains, though successful transition may require careful judgment to the appropriate timing and place of referral to further care (Rosenheck & Dennis, 2001). Improvement with respect to measures of health status and community adjustment was observed from baseline to follow-up across all time points. Service utilization measures increased in the first 3 months but declined thereafter, though still remaining higher than at baseline. Clients discharged after having successfully completed ACT (3%) had better outcomes on all measures but did not receive significantly fewer services. Clients who were referred to high or low intensity case management (6%; 26%) had superior outcomes on several clinical measures and greater levels of service utilization. Those referred to substance abuse or dual-diagnosis treatment programs (8%) had poorer drug and alcohol outcomes perhaps suggesting special problems in those health areas. Supported housing referrals (11%) were associated with greater reduction of psychiatric symptoms, alcohol and drug problems, better housing outcomes, and better quality of life. Clients who continued with ACCESS ACT (19%) showed greater reductions in alcohol problems and greater service use at 18 months. Those discharged to psychiatric inpatient facilities (0.3%) had fewer alcohol-related problems but more inpatient and outpatient service use.

The authors identified two key implications of the findings for development of case management services for the severely mentally ill. First, the advantages of ACT can be sustained after transfer when clinicians have the flexibility to make the decision if a client is ready for transfer to other services. Second, there should be links between systems serving homeless people with severe mental illness and mainstream mental health services to facilitate transfer when appropriate so that services can be available for untreated homeless clients.

- 18. Authors:** Brashler, R.
Title: The Trauma of Discharge Planning following Brain Injury
Sources: The Journal of Clinical Ethics, 2004

Discharge planning is defined as what professionals view as the myriad of activities that are associated with the transition from the hospital to the community. This article talks about the challenges a family faces in discharge planning and after-care, healthcare team responses to discharge planning, and ethics in discharge planning. Families often feel scared, uncertain, and unready when a family member is being discharged and preparation should therefore begin early. Counseling and emotional support should be provided to families as well as support to help care discharged family members. The healthcare team deals with the stressors of facing a family's frustration, frustration with restrictions on clinical judgment by insurance companies, time constraints, and doubts about their own competence. These frustrations sometimes are projected onto the family and/or client which negatively affects a client's care. Healthcare providers are called upon to advocate for the rights of discharged patients to receive appropriate after-care.



- 19. Authors:** Help the Aged
Title: The discharge of older homeless people from hospital
Sources: London, UK: Help the Aged, 2003

This report from an agency in the UK highlights needs and issues facing older homeless people at discharge. Homeless people in their 50s and 60s have a high morbidity rate and often have health problems associated with much older groups. The report argues that health and social care agencies must work in close partnership with housing providers and homelessness agencies if the opportunities that in-patient treatment can offer to link this group into services in the community are to be realized (authors). Hospital admission of homeless people over the age of 50 was higher than the general public. Self-discharge was found to be a frequent outcome for this group and there are few incentives to dissuade them as they have complex needs. Re-housing for older homeless adults was difficult as many had "burned their bridges" with housing providers and did not want sober living arrangements. Placements and funding were limited especially for those aged between 50 and 60. Social workers felt that having an official liaison within the housing department, clear referral procedures, agreements for conducting homeless assessments in the hospital, and regional procedures for the discharge of out-of-area homeless patients would or had been beneficial in attaining housing for clients. Seven service provision and policy models were identified that successfully worked with the identified population. Common themes of the program highlighted the importance of training of and communication between staff, collaboration and appropriate referral between service providers, and securing of housing. The government should recognize the existence and implications of homelessness among older adults, research the incidence of admission and discharge outcomes, consider ways of setting and monitoring the discharge of homeless patients, set good practice guidance procedures for discharge, and ensure housing departments and providers are involved in establishment of intermediate care schemes and mental health teams. Local policies and procedures should ensure the establishment of training for hospital staff on homeless issues and services and joint protocols agreed upon by hospitals, social services, housing departments, housing providers, and homeless agencies to identify, monitor, serve, and appropriately refer homeless patients. Social service providers should consider the needs of homeless people aged between 50 and 65 that may have needs usually associated with much older groups, recognize the opportunity that hospital admission can provide for contact with this hard-to-reach group, and investigate models of service provision. Further research should include re-admission rates for homeless people, incidence of admissions and discharges, incidence of and risk associated with self-discharge, and models of supported housing that could meet the needs of older women with mental health problems.



- 20. Authors:** Tuzman, L., Cohen, A.
Title: Clinical Decision Making for Discharge Planning in a Changing Psychiatric Environment
Source: Health & Social Work Vol. 17(4), 1992

The authors recognize that a large percentage of homeless are deinstitutionalized mentally ill people. This continuing deinstitutionalization calls for focus to be placed on the role of discharge planning in the acute psychiatric hospital. The authors propose an interactive model for discharge planning that affects the social worker's interventions, tasks, and actions at each stage of hospitalization. The social worker must deal with and constantly assess the influence of environmental, organizational/institutional, clinical, and community-based forces. The authors state that the discharge planning process can be broken down into decision-making time frames where a social worker can conduct a needs assessment and intervention. An example using an average 35-day hospital stay is provided. The model is based on a social work program for discharge planning. The program is centralized and provides assistance with referral processes, resource information, accountability, education and case consultation, research and follow-up (Tuzman & Cohen, 1992). Centralization also provides a knowledge base and predictive structure that can be used in each case. The program is driven by a value system that emphasizes communication with and providing sufficient information to patient and family, assurance or enhancement of patients social, emotional, physical functioning, and the achievement of the highest quality of life.

Social workers are identified as being the key players who carry most of the burden of discharge planning in health care. The discharge planning process involves synchronization of four elements – resource availability, hospital discharge date, patient readiness, and family readiness and social workers ability to handle these different elements at once can affect quality of discharge plan.

- 21. Authors:** Houghton, T.
Title: Ending Chronic Homelessness Among People with Mental Illness: The Community Model
Sources: Los Angeles, CA: Commissioned by Shelter Partnership, Inc., Lamp Community, OPCC, RAND Corporation, 2005. (Manual: 125 pages)

This manual is an information guide for service providers and policymakers on how to incorporate the Community Model into programs for chronically homeless people. The Community Model was developed by LAMP Community in Los Angeles over the past two decades. This model "is a comprehensive method of service provision that has helped thousands of homeless people with mental illness achieve residential stability and an improved quality of life. Employing harm reduction service strategies in a safe, flexible and non-hierarchical environment, the Community Model allows people to tailor their own paths to recovery and wellbeing" (cite). The model has been effective at serving those who are difficult-to-engage namely the dually-diagnosed and other members of the chronically homeless population. The model is driven by the principles of harm reduction where the focus is on improvement of quality of life and the gradual reduction of the negative consequences of drug use and mental illness; and by community building where members are encouraged to explore their own strengths and how they can contribute to the community. The model also provides housing, service, and support components. A primary goal of the model is to first end a client's homelessness and provide residential stability. According to the model, once stabilized in housing, other positive outcomes such as decrease in psychiatric instability and substance use will follow.



- 22.** **Title:** Estimated Cost Savings Following Enrollment in the Community Engagement Program: Findings from a Pilot Study of Homeless Dually Diagnosed Adults
 Source: Los Angeles, CA: Central City Concern, 2006

This report discusses the estimated cost-benefits of providing community based therapeutic care and case management to adults experiencing chronic homelessness and multiple disabling conditions. Many of the social costs attributable to the chronically homeless, dually diagnosed individuals are spread across a spectrum of social, health care, and safety services that encompass both public and private entities. The CEP is modeled after the Program of Assertive Community Treatment (PACT) model; which, includes services for intensive treatment, rehabilitation, and support services in the homes, on the job, and other social settings. The primary site of treatment is the community and not the hospital. The results of this study found that before the program the estimated costs for servicing a client was \$42,075. When the client went through CEP the estimated cost was \$8,991. Experience suggests that the first year of treatment is the most expensive. Based on this, it is highly recommended that further studies, over a greater period of time, be undertaken to demonstrate the on-going cost savings of the CEP approach as clients remain stabilized in the community over multiple years.

- 23.** **Authors:** Pages, K. P., M.D., Russo, J. E., Ph.D., Wingerson, D. K., M.D., Ries, R. K., M.D., Roy-Byrne, P. P., M.D., and Cowley, D. S., M.D.
 Title: Predictors and Outcome of Discharge Against Medical Advice from the Psychiatric Units of a General Hospital
 Sources: Psychiatric Service 49(9), September 1998

This study examined predictors of discharge against medical advice (AMA) and outcomes of psychiatric patients with AMA discharges, as measured by poorer symptoms ratings at discharge and higher rates of re-hospitalization (authors). 195 patients discharged from hospital psychiatric units were compared retrospectively with 2,230 regularly discharged patients. AMA patients have significantly worse outcomes at discharge, higher scores on the Psychiatric Symptom Assessment Scale, greater suicidality, more anxiety and hostility-aggression, were more uncooperative and had poorer insight into their illness than patients regularly discharged (authors). Client at risk of being AMA discharged must be identified early so that discharge planning can begin early. It is also suggested that transition to outpatient treatment be facilitated regardless of discharge status.



- 24. Authors:** Harris County Psychiatric Center
Title: Patient Discharge Refusal
Sources: Houston, TX: University of Texas, Harris County Psychiatric Center Policy (UTHCPC), 2007

UTHCPC's policy is to work with a patient on discharge plans. UTHCPC has provided a guide to identify patients who may potentially refuse discharge. In order to identify a client who may refuse discharge a clinician should report to his/her supervisor those who are at high risk, the treatment team attempts to understand a patient's reason to refuse, the clinician and director work with the physician and team to establish a back-up plan, and the team attempts to meet the patient's request regarding discharge options. When a patient refuses to leave at discharge the nursing staff should notify the physician and the clinician notifies the patient relations representative, the nurse manager, the social service director, and the hospital risk manager. If refusal continues the clinician will call a patient case conference that will include the attending physician, medical director, director of nursing/designee, and the hospital risk manager. The clinician then notifies the medical director/designee, hospital risk manager, administration, and attorneys if the team supports discharge against the patient's will.



HOSPITALS and HEALTH CARE

1. **Authors:** American Association of Community Psychiatrists
Title: Continuity of Care Guidelines: Best Practices for Managing Transitions Between Levels of Care
Source: Dallas, TX: American Association of Community Psychiatrists, 2001 (Guidelines: 9 pages)

These guidelines were prepared to assist providers and planners in establishing standards for the management of transitions between levels of care, and are intended to provide a quality management framework by which systems of any type can continuously monitor and improve their processes for managing client transitions. The authors assert that the continuing engagement with treatment and recovery services is one of the most important aspects of addressing an episode of illness or ongoing disabilities associated with severe behavioral health problems. The authors also state that **interruption of care, for whatever reason, is among the most significant obstacles to establishing a stable recovery** and it is in response to these circumstances that these guidelines were created (authors). Available From: American Association of Community Psychiatrists, P.O. Box 570218, Dallas, TX 75228, (972) 613-0985, <http://www.comm.psych.pitt.edu/finds/COG.DOC>

2. **Authors:** McMurray-Avila, M
Title: Medical Respite Services for Homeless People: Practical Models
Source: National Health Care for the Homeless Council, 1999

In this report, the author explores medical respite care models to address healthcare issues of homeless people after discharge from a hospital. As hospital stays become shorter, it is expected that patients are able to access family members for post-discharge care at home. But when there is no home to discharge to, there is an increasing awareness of the need to find alternatives to discharging patients to the streets or to shelters that lack the facilities to provide for a healthy recuperation period. In this context the term "respite care" has emerged to describe recuperative of convalescent service needed by homeless people with medical problems. To distinguish from 24 hr shelter beds, the defining factor of respite care is the provision of medical services, with nursing as a minimum.



3. **Authors:** Anthony, M.K., Hudson-Barr, D.C.
Title: Successful Patient Discharge: A Comprehensive Model of Facilitators and Barriers
Source: Journal of Nursing Administration 28(3):45-55, 1998

In this article, a model of factors that promote and inhibit effective discharge from three nursing practice specialties across three practice settings is described. Decreased length of stay (LOS) has resulted from recent healthcare delivery shift from fee for service to managed care, thus the need for effective discharge planning by nurses is more urgent and complex. In high-performance discharge teams that include multiple care providers, the RN is crucial in identifying and evaluation patient and family preparedness. They are care givers within the team who provide continuous care during a patient's hospital admission. Four themes were found to be common across sites and specialties –

1. characteristics of nurses (experience, availability, continuity, access to resources),
2. tools for discharge (availability of care paths, clarity of discharge criteria).
3. communication (bet. RN and physician, bet. Patient and family, bet. RNs, bet. Hospital and outside agencies),
4. patient readiness to leave.

These 4 factors provide a comprehensive framework to work within when designing interventions for successful discharges.

4. **Authors:** Birmingham, J.
Title: Discharge Planning Guide: Tools for Compliance
Source: HCPro, Inc., 2004

This book provides information on existing legislation and how it strengthens the discharge planning process. It also gives a brief history of the development of discharge planning as a process, leading to the social security amendment for discharge planning. In 1986, the Emergency Medical Treatment and Active Labor Act was passed and prevented "dumping" from the Emergency Dept. Today, any hospital that receives federal funding, regardless of the patient's payer, is entitled to and must receive discharge planning services. Aimed at hospital administrators, the author offers information on how to manage the line between moving patients quickly and compliance issues. It includes chapters on dealing with patients with Limited English Proficiency (LEP), a web resource list, and a CD-Rom with sample discharge planning tools created at a medical hospital. The author reiterates that the legislation and regulations that drive discharge planning are constantly evolving and what is cited in the book is not intended to replace legal advice on compliance with discharge planning regulations. The author was director of discharge planning at Hartford Hospital from 1983-1993.



5. **Authors:** Bendixen, A. and Pacura, L.
Title: Hospital Discharge: How Partnership Can End Homelessness
Source: May Leadership to End Homelessness Audio Conference, National Alliance to End Homelessness. Thursday, May 11, 2006 at 3pm ET www.naeh.org

The May Leadership to End Homelessness Audio Conference Series will focus on how housing and services for homeless individuals benefit homeless individuals as well as the health care industries bottom-line. People living on the street frequently do not receive the medical care they need and their poor health condition is exacerbated by not having adequate shelter. All too often those experiencing homelessness are hospitalized for treatment and then discharged into unsuitable accommodations or back into homelessness. Hospitals, along with the rest of the health care industry, are beginning to acknowledge that addressing clients' lack of housing is in their best interests. There is a revolving door between the street and the hospital that can be stopped if individuals are housed. Addressing these individuals' needs can also improve a hospital's bottom-line because homeless individuals and families are often uninsured and are not able to pay medical bills.

It is essential that there are strong links between hospitals, the local homeless service providers, and other social service agencies to ensure that people are not discharged into homelessness.

The audio conference features Arturo Bendixen (Aids Foundation of Chicago) and Lori Pacura (Mt. Sinai Hospital). They are both very involved with the Chicago Housing for Health Partnership(CHHP) and speak about the research component of the project and how CHHP can be a model in serving the homeless population coming out of hospitals.

Chicago Housing for Health Partnership (CHHP)-Collaborative of 3 hospitals, 2 respite care, 11 housing agencies, and shelters. Housing first approach. Funding from HUD SHP – 120 units of housing

Research component – experimental design – half released from hospital in control, other half in CHHP intervention (Chicago housing for health). Recruited over 400 people to participate in research. Intervention group housing with intensive case mgrs. People were able to get housing and stay housed, 60% of them compared to the control in group, a decrease in hospital stays, ER visits, etc. although preliminary data, looks good. Everyone gets interviewed at 3, 6, 9 months about use of medical services, housing, etc. Created wonderful partnership with Mt. Sinai Hospital. It pays off to house people with chronic medical illness.



6. **Authors:** Moody, H.R..
Title: Hospital Discharge Planning: Carrying Out Orders?
Source: Journal of Gerontological Social Work 43(1):107-118, 2004

Social workers working in hospital discharge planning face recurrent conflicts between patients' rights and the pleasures of managed care. What should professional do when confronted with orders that violate their conscience even where they do not violate the law? Exemptions for hardship or religious identity may or may not provide a basis for case-by-case decision making. When confronted by ethical conflicts, discharge planners may be tempted to manipulate diagnostic categories in order to prolong a hospital stay. **A better approach is to change policy at the institutional level so that professionals are not faced with a choice between sacrificing themselves or following ethical standards as patients prepare to leave the hospital.** (author)

Author uses case example of nurse hoping patient gets pneumonia so there would a pretext for staying a few more days at the hospital. His diagnosis brought him more time, enough to arrange for a proper transfer to a nursing home where his family could visit him. The article goes on to talk about what happened at that hospital when a health consulting group was brought in to assess hospital stays. The consultants went against established regulations and told social work staff to discharge patients to the first nursing home with an open bed as soon as they were able to leave the hospital, even if that patient would have preferred another nursing home that they were more familiar with or that their families lived closer to. This case illustrates the conflict between patient rights versus health cost-containment. Each extra day in the hospital can cost \$1000 or more and this expense may not be reimbursed by Medicare if a patient falls outside of DRG categories permitting length of stay. The advent of DRGs and managed care in the 1980s created an environment where hospital administrators were pressured financially, to discharge Medicare patients "sicker and quicker".

Based on what the author knows about this case, the state regulations that govern alternate levels of care for patients sound good in theory but there is no guarantee patients will be involved in decision about when they leave and where they will go. Proper procedures can easily fail to do what they set out to and discharge planners can very well manipulate patients and their families by not presenting the whole picture.



7. **Authors:** Fairchild, D.G., Hickey, M.L., Cook, F.E., McCarthy, R.M., Rossi, L.P., Timmons, S.C., Mangione, C.M., Lee, T.H.
Title: A Prediction Rule for the Use of Post discharge Medical Services
Source: Journal of General Internal Medicine 13: 98-105, 1998

This article describes a study at an urban teaching hospital to develop and validate a prediction rule screening instrument that could facilitate discharge planning by identifying patients at the time of admission who are most likely to need post discharge services. A screening instrument administered at the time of admission identifying those patients most likely to need discharge planning services could make the process more efficient by targeting their efforts at the most at-risk population. The study concluded that further research is necessary to determine whether prospective identification of patients likely to need discharge planning will make the hospital discharge planning process more efficient.

The article uses a traditional definition of discharge planning – helping patient's transition from the hospital to the community. The author notes that more recently, discharge planning has been redefined as “social health care management” (Blumenfield & Rosenberg, 1988), with services available from preadmission to post hospital discharge.

Of the 10 tasks required to perform, 8 also ranked as the most important tasks. The provision of concrete services after discharge is the most basic and essential component of discharge planning.

8. **Authors:** Iglehart, A.
Title: Discharge Planning: Professional Perspectives Versus Organizational Effects
Source: Health and Social Work 15(4): 301-309, 1990 (Journal Article: 9 pages)

This article discusses the rise in legitimacy and visibility of hospital discharge planning, which has been accompanied by competition between social work and nursing over control of this function. The author used a survey of 229 California hospitals to test the hypothesis that the discharge planning process is the same regardless of the discipline or department in which it is located. The **article states that the only significant difference among the social work, nursing, and administrative departments was in the type of staff used.** The author asserts that social work departments were more likely to have both a social worker and a nurse on the discharge planning staff and on the discharge planning team. *Nursing tends to focus more on medical needs.* More collaborative bonds between social work and nursing is suggested (author).



9. **Authors:** Holliman, D., Dziegielewska, S., Teare, R.
Title: Differences and Similarities Between Social Work and Nurse Discharge Planners
Source: Health and Social Work 28(3): 224-231, 2003 (Journal Article: 7 pages)

This article discusses how, historically the tasks involved in discharge planning have been a part of the practice of social work as well as the field of nursing. Based on a study conducted in 1998, which measured the responses of 178 nurses and social workers who practiced discharge planning in 58 different hospitals in Alabama, the authors state that social workers as well as nurses continued to be important service providers in the area of discharge planning. The article states that demographic data, work setting, caseload, and task difference were compared and significant differences were reported. This article makes recommendations for social work's participation in advocacy, policy, and outcome research in discharge planning (authors).

10. **Authors:** Rodriguez, L.
Title: Discharge Planning Safety Considerations: Safety Considerations that Impact an Individual Wishing to Live in the Community
Sources: Los Angeles, CA: Homeless Health Care Los Angeles; Homelessness: An Overview and Effective Strategies for Discharge Planning of Homeless Patients, 2006.

A listing of issues is provided that should be reviewed as part of a discharge plan to identify patient safety concerns. These issues are: individual capacity issues such as sensory deficits; environmental issues such as unsafe housing and lack of support; and provisions of service issues such as lack of transportation and insurance coverage. Policy and process elements are listed as key elements for effective and safe discharge planning to facilitate an individual's right to choose. Clear policies, protocols and standards, early planning and intervention, privacy standards, a resource database, coalition building with resources, realistic service plans, available care management, and patient education are part of the policy component of a discharge plan. A discharge plan process should include person-centered assessment, communication and coordination among caregivers and stakeholders, support from a multi-disciplinary team, collaboration with advocates, and peer support.



11. **Authors:** Rodriguez, L.
Title: What the Discharge Planner Needs to Know in Order to Effect a Safe and Efficient Transition
Sources: Los Angeles, CA: Homelessness: An Overview and Effective Strategies for Discharge Planning of Homeless Patients, 2006

A list of questions a discharge planner should review when working with an individual as part of a discharge plan. A discharge planner should be aware of a person's baseline information such as their medical and psychological status and their support systems. Medical providers and prior service utilization should be identified. Expectations of the medical team, client, and supports should be identified. Identification, assessment, and education of who will be providing post-discharge care is also listed. Available resources and environmental limitations of patient's residence are also important.

12. **Authors:** Brashler, R.
Title: The Trauma of Discharge Planning following Brain Injury
Sources: The Journal of Clinical Ethics, 2004

Discharge planning is defined as what professionals view as the myriad of activities that are associated with the transition from the hospital to the community. This article talks about the challenges a family faces in discharge planning and after-care, healthcare team responses to discharge planning, and ethics in discharge planning. Families often feel scared, uncertain, and unready when a family member is being discharged and preparation should therefore begin early. Counseling and emotional support should be provided to families as well as support to help care discharged family members. The healthcare team deals with the stressors of facing a family's frustration, frustration with restrictions on clinical judgment by insurance companies, time constraints, and doubts about their own competence. These frustrations sometimes are projected onto the family and/or client which negatively affects a client's care. Healthcare providers are called upon to advocate for the rights of discharged patients to receive appropriate after-care.



13. **Authors:** Help the Aged
Title: The discharge of older homeless people from hospital
Sources: London, UK: Help the Aged, 2003

This report from an agency in the UK highlights needs and issues facing older homeless people at discharge. Homeless people in their 50s and 60s have a high morbidity rate and often have health problems associated with much older groups. The report argues that health and social care agencies must work in close partnership with housing providers and homelessness agencies if the opportunities that in-patient treatment can offer to link this group into services in the community are to be realized (authors). Hospital admission of homeless people over the age of 50 was higher than the general public. Self-discharge was found to be a frequent outcome for this group and there are few incentives to dissuade them as they have complex needs. Re-housing for older homeless adults was difficult as many had “burned their bridges” with housing providers and did not want sober living arrangements. Placements and funding were limited especially for those aged between 50 and 60. Social workers felt that having an official liaison within the housing department, clear referral procedures, agreements for conducting homeless assessments in the hospital, and regional procedures for the discharge of out-of-area homeless patients would or had been beneficial in attaining housing for clients. Seven service provision and policy models were identified that successfully worked with the identified population. Common themes of the program highlighted the importance of training of and communication between staff, collaboration and appropriate referral between service providers, and securing of housing. The government should recognize the existence and implications of homelessness among older adults, research the incidence of admission and discharge outcomes, consider ways of setting and monitoring the discharge of homeless patients, set good practice guidance procedures for discharge, and ensure housing departments and providers are involved in establishment of intermediate care schemes and mental health teams. Local policies and procedures should ensure the establishment of training for hospital staff on homeless issues and services and joint protocols agreed upon by hospitals, social services, housing departments, housing providers, and homeless agencies to identify, monitor, serve, and appropriately refer homeless patients. Social service providers should consider the needs of homeless people aged between 50 and 65 that may have needs usually associated with much older groups, recognize the opportunity that hospital admission can provide for contact with this hard-to-reach group, and investigate models of service provision. Further research should include re-admission rates for homeless people, incidence of admissions and discharges, incidence of and risk associated with self-discharge, and models of supported housing that could meet the needs of older women with mental health problems.

14. **Authors:** Williams, M.E., Kitsen, J.
Title: The Involuntary Discharged Dialysis Patient: Conflict (of Interest) With Providers
Sources: Advances in Chronic Kidney Disease 12(1), January 2005, pp 107 -112

This article focuses on the challenging treatment of end-stage renal disease (ESRD) and conflict between patient and staff because of involuntary discharge. Conflicts of interest exist because of different situations ranging from noncompliance to abusive behavior. Healthcare providers should develop skills to deal with nonconforming patients but policy should also exist to protect patients and staff from disruptive and violent patients. Professional staff require training to recognize and evaluate challenging patients. Comprehensive regulations are also needed to establish standards and procedures regarding involuntary discharge.



15. **Authors:** Harris County Psychiatric Center
Title: Patient Discharge Refusal
Sources: Houston, TX: University of Texas, Harris County Psychiatric Center Policy (UTHCPC), 2007

UTHCPC's policy is to work with a patient on discharge plans. UTHCPC has provided a guide to identify patients who may potentially refuse discharge. In order to identify a client who may refuse discharge a clinician should report to his/her supervisor those who are at high risk, the treatment team attempts to understand a patient's reason to refuse, the clinician and director work with the physician and team to establish a back-up plan, and the team attempts to meet the patient's request regarding discharge options. When a patient refuses to leave at discharge the nursing staff should notify the physician and the clinician notifies the patient relations representative, the nurse manager, the social service director, and the hospital risk manager. If refusal continues the clinician will call a patient case conference that will include the attending physician, medical director, director of nursing/designee, and the hospital risk manager. The clinician then notifies the medical director/designee, hospital risk manager, administration, and attorneys if the team supports discharge against the patient's will.

16. **Authors:** The Effort
Title: The Effort: Primary Care Interim Care Project (ICP)
Sources: www.theeffort.org, retrieved Jul 2007

The Effort is an agency in Sacramento, CA that offers a variety mental health and social service programs with an emphasis on the importance of supporting a family in order to support an individual. The Interim Care Project (ICP), opened in March 2005, is a hospital system collaborative effort lead by The Effort in order to provide respite care for discharged homeless patients. Funding is provided by Kaiser Permanente, Mercy, Sutter Medical Center, Sacramento, UC Davis Medical Center, and the County of Sacramento. Discharged hospital patients in need of on-going follow-up care are referred to one of the eighteen beds reserved in the Salvation Army shelter. Clients are able to recover in a supportive setting where they also receive case management services that link them to mental health, substance abuse, housing, and disability application services. Client can stay for up to six months although the average length of stay is 24 days. Some program and client stats are that: 48% of clients have Medi-Cal coverage; 47% of clients have no insurance and/or qualify for the County Medically Indigent Services Program (CMISP); 5% of clients had Veteran's Administration or other coverage; 80% of participants received mental health services while in the program; All participants are offered substance abuse treatment services on-site; 81% of participants moved from the Interim Care Program into housing (permanent supportive housing, transitional housing, shelter, board and care, etc.); Cost per bed per day = \$120 (compared to hospital inpatient cost of \$1,200 per day).



17. **Authors:** Lightman, E.S.
Title: Discharge Planning and Community Housing in Ontario
Source: In Aviram, U. (ed.), *Social Work in Mental Health: Trends and Issues*. Binghamton, NY: The Haworth Press, 63-75, 1997. (Book Chapter: 13 pages)

This chapter discusses the lack of sufficient community supports available to assist vulnerable persons discharged from hospitals in Ontario, Canada, with no place to go. The process by which vulnerable adults end up in unsuitable community settings as a result of deinstitutionalization is explored. The article places particular focus on the difficult role played by the discharge planner as conduit from hospital to community. The author discusses the situation of the planner being caught in the middle, facing hospital directives to empty beds, alongside an acute shortage of suitable housing in the community. The problem with many persons being discharged to unregulated housing is presented. Discharge planners' roles as well as implications for future discharge planning are also discussed (author).

18. **Authors:** National Association of State Mental Health Program Directors
Title: State Hospital Discharge Planning Policies and Procedures
Source: Alexandria, VA: National Association of State Mental Health Program Directors, 1992 (Report: 38 pages)

In this study, 39 states identified 45 distinct elements of discharge planning policies and procedures, and their relationship to homelessness. Attached is a state-by-state matrix of the 45 distinct elements. Many states may actually do more than is contained in their written policies; this analysis merely lists what is contained in written policies (authors). Available From: National Association of State Mental Health Program Directors, 66 Canal Center Plaza, Suite 302, Alexandria, VA 22314, (703) 739-9333, www.nasmhpd.org. (COST: \$25.00).

19. **Authors:** Mendel, P., Fuentes, S.
Title: Summary of Community Feedback Conference: Held at the USC Davidson Conference Center, July 2006
Source: Los Angeles, CA: Health Care for Communities Partnership Initiative, 2006

The purpose of this study is to develop a collaborative approach to identify and assess aspects of organizational capacity that are associated with successful community partnerships around improving mental health and substance abuse outcomes. This study combines the two goals of "tracking" community information and developing a collaborative approach because, in the context of communities, tracking and assessment can often be viewed as exploitative or designed solely for the purposes of researchers or the academic establishment, even when implemented in a participatory manner. The specific aims of the study are to: 1) identify the different capacities, strengths, and sets of expertise that local organizations bring to addressing mental health and substance abuse issues in a community; 2) map out current inter-agency partnerships and collaborative experiences around these issues; and 3) explore how organizations can work together to achieve community mental health and substance abuse goals.



20. **Authors:** Interagency Council on the Homeless.
Title: Exemplary Practices in Discharge Planning: Working Conference on Discharge Planning Report and Recommendations
Source: Washington, DC: Interagency Council on the Homeless, 1997. (Report: 19 pages)
- The Interagency Council on the Homeless convened a Working Conference on Discharge Planning in June 1997 to identify and build consensus for the key elements of effective discharge planning and to develop recommendations for exemplary discharge planning practice. The statements and recommendations in this report represent the consensus of the Working Conference. They are organized in five categories: roles and responsibilities; elements of an effective discharge plan; collaboration and partnerships; and funding and cost issues. This report is intended to assist states, institutions and facilities, local communities, and the Department of Veteran Affairs to develop and implement effective discharge planning systems and practices.
21. **Authors:** Moss, J.E., Flower, C.L., Houghton, L.M., Moss, D.L., Nielsen, D.A., Taylor, D.M.
Title: A Multidisciplinary Care Coordination Team Improves Emergency Department Discharge Planning Practice
Source: MJA 177, 2002.

In July 2000, a Care Coordination Team (CCT) was created to address an increasing demand for hospital services at Royal Melbourne Hospital that was found to be caused by a shortage in aged-care beds and a need for post-acute care. The CCT was comprised of nursing and allied health personnel. The target population included frail elderly, those living alone, the homeless, those who frequently came to the emergency department, and those with drug and alcohol problems. 2532 patients were identified by triage staff using a risk screening tool. The CCT utilized a comprehensive risk assessment where priority was first given to those whom unnecessary or inappropriate admission could be prevented and then to those requiring complex discharge planning. The risk assessment involved "documentation of expected discharge date and destination, existing services and supports, and include[d] prompts for referral to internal and external health professionals" (Moss et. al, 2002, p. 428). The CCT discharge referral sources included 24/7 access to home services through a post-acute-care emergency department unit (which included home care, personal care, physiotherapy, occupational therapy, transport, and childcare), a homeless persons nursing program, and working relationships with other service providers. The CCT service was assessed after 12 months and found that significantly fewer patients were admitted and readmitted to the hospital, nearly half of the participants were discharged home with referrals to service providers, there was a lack of adverse events found after discharge, and staff, patients, caregivers, and community service providers responded that they were highly satisfied with the CCT when surveyed. The study identified variations in staffing levels, time constraints, resource limitation, and eligibility criteria as issues that may affect successful implementation of CCT services and discharge planning. The authors "recommend this model, and the extension of community support services, to assist in the disposition of patients after acute care in emergency departments" (Moss et. al, 2002, p. 431).



22. **Authors:** Medical University of South Carolina
Title: Discharge Planning at the Medical University of South Carolina
Sources: Charleston, SC: Medical University of Southern California, 2003

This booklet was created as an informational guide for family caregivers involved in the discharge planning of a relative. The guide answers frequently asked questions, reviews what the caregiver and family member need to know, defines roles of those involved, emphasizes the importance of collaboration and communication with the healthcare team and the necessity of early planning. The basics of a discharge plan are broken down into four steps: discussion, planning, training, and referrals. Each step describes how those involved in the patient's discharge plan work together to gather information, assess and address patient needs, and prepare for care after discharge.

In addition to the discharge planning booklet for caregivers, The Medical University of South Carolina (MUSC) has created documents to guide members of the healthcare team throughout the discharge planning process. MUSC's *Discharge Planning Manual* outlines the procedure from point of admission, during admission, to discharge. Each member's role is clearly defined. *Assessment of Needs for Continuing Care* is an assessment of socio-demographic factors, health status, functional status, environmental factors in post-discharge care, nursing and other care requirements, family and community support, patient/family goals and preferences, and options for continuing care. *Discharge Orders* is a record of attending physician, discharge diagnoses and procedures performed, follow-up appointments, patient disposition, discharge medications, if client is cleared for discharge, continuing care orders, appointments, community services, and follow-up phone numbers. The patient and designated healthcare team members must sign the record and the patient is given a copy of pertinent information. *The Ideal Discharge Process* and *Ideal Discharge Process: Role Model* handouts outline the key steps of a thorough and expedited discharge process and the duties of the care manager and physician in this process.



23. **Authors:** Kadushin, G., Kulys, R.
Title: Discharge Planning Revisited: What Do Social Workers Actually do in Discharge Planning?
Source: Social Work 38(6): 713-726, 1993. (Journal Article: 13 pages)

This article discusses whether discharge planning has a primarily focus on the provision of concrete services, counseling, or both. The authors asserts that, within a structured interview format, eighty social workers in thirty-six acute care hospitals were asked to estimate the amount of time they spent on and the importance of seventy-three discharge planning tasks. The article states that respondents were also asked to locate themselves on an activity continuum. The survey results are discussed in terms of the prospective payment system's emphasis on expeditious discharge and the challenge to social workers in enabling patients and families to have some control over decision making in this climate (authors).

Discharge planning in hospitals is still performed primarily by social workers (cited 1990 source). Cost containment measures enacted since 1983 have propelled discharge planning into a central role in the hospital, enhancing the importance and prestige of discharge planners. With the exception of two studies completed more than 20 years ago, there is little empirical research on discharge planning. This study sought to find out from social workers engaged in discharge planning what they actually do and how they relate in importance to carrying out their jobs as discharge planners. (adapted from article). The study was designed to answer three questions: 1) How much time do social workers spend performing specific discharge planning tasks? 2) How important are these tasks to accomplishing the objectives of discharge planning? 3) Where do these tasks belong on the discharge planning continuum?

The article uses a traditional definition of discharge planning – helping patient's transition from the hospital to the community. The author notes that more recently, discharge planning has been redefined as "social health care management" (Blumenfield & Rosenberg, 1988), with services available from preadmission to post hospital discharge.

Of the 10 tasks required to perform, 8 also ranked as the most important tasks. The provision of concrete services after discharge is the most basic and essential component of discharge planning.



24. **Authors:** Maramba, S.R., Myers, A.L., Larrabee, J.H.
Title: Discharge Planning Process: Applying a Model for Evidence-based Practice
Source: Journal of Nursing Care Quality 19(2): p123-129, 2004

A research utilization (RU) project was undertaken at a teaching hospital to introduce more staff nurses to research-based practice regarding staff nurses' roles in the discharge process. Issues that negatively affected discharge planning were identified as ill-defined roles for staff nurses involved in discharge planning, decreased length of hospital stay and therefore time to assess post-discharge needs, and poor communication between healthcare team members. Results of an inadequate process were likely to lead to inefficient utilization of community resources, inadequate self-care, and readmission.

- 1) **Client and family satisfaction--** Client and family understanding of the client's condition, feeling prepared to manage post-discharge care, and being involved in decisions related to discharge planning were predictors of satisfaction.
- 2) **Components of the discharge planning process--** Integral components identified were use of a designated discharge coordinator, enhanced communication among all parties involved with patient care, use of a standardized process, and assessment of the patient's clinical and social situation. Increased age and low social and physical function increased need for and likelihood of use of discharge services.
- 3) **Designated discharge coordinator--** Utilization of a designated discharge coordinator was identified as a strategy to facilitate discharge planning and increased patient satisfaction. Adequacy ratings of discharge plans were significantly influenced by factors including length of stay, extensive need for assistance or nursing attention, inadequate caregiver support, and availability or affordability of post-discharge resources. Readmission was high for males and those without adequate support systems.
- 4) **Comprehensive discharge protocol--** Combined use of a comprehensive discharge protocol and use of a discharge coordinator trained to use the protocol improved planning, imparted consistency in the delivery of information, and reduced problems experienced by patients post discharge. Patient length of stay was increased with use of a discharge coordinator.

25. **Authors:** Buchanan, D., Doblin, B., Sai, T., Garcia, P.
Title: The Effects of Respite Care for Homeless Patients: A Cohort Study
Sources: American Journal of Public Health 96(7), 2006

An investigation of 225 hospitalized homeless adults who were referred to a 64-bed respite care provider was conducted over a 26-month period (from October 1, 1998 to December 31, 2000). The cohort was split into two groups: patients referred and accepted for respite care (161 persons); and those referred but denied due to space issues (64). The groups had similar demographic characteristics, diagnoses, and medical care use at baseline but during the 12 months of follow-up the respite care group had fewer hospital days than the second group. HIV/AIDS clients experienced the greatest reduction in hospital stays. The respite care provider offered homeless patients round-the-clock services including, interim housing, acute health care, counseling, case management, and referrals to permanent housing. Respite care was estimated at costing \$706 per day versus \$1500 per day for hospital costs. The authors conclude that "respite care after hospital discharge reduces homeless patients' future hospitalization" (Buchanan, et al., 2006).



26. **Authors:** California Legislature, Assembly Member Jones
Title: Assembly Bill 2745 Hospital Dumping
Sources: California Legislature, 2006

Assembly Bill 2745 (AB 2745) was introduced to the California legislature on February 24, 2006 by Assembly member Dave Jones. The Assembly concurred with Senate amendments on August 31, 2006. Assm. Jones' bill addresses discharge planning of homeless patients from hospitals. The bill makes specifications for existing law that "requires each hospital to have in effect a written discharge planning policy and process that requires that each patient be informed, orally or in writing, of the continuing care requirements following discharge from the hospital, as specified" (cite ab2745). AB 2745 requires that hospitals conduct regional planning meetings, where the county board of supervisors, law enforcement, and other stakeholders are invited to attend, "to improve post-hospital transition of homeless patients as specified" (cite ab2745). The outcomes and findings of these meetings must be documented by January 1, 2008. The bill also prohibits the "dumping" of homeless patients from one county to another and requires that initiating service providers properly notify and get authorization from receiving service providers before transfer.

27. **Authors:** Grimmer, K., Moss, J., Falco, J., Kindness, H.
Title: Incorporating Patient and Career Concerns in Discharge Plans: The Development of a Practical Patient-Centered Checklist
Sources: The Internet Journal of Allied Health Sciences and Practice 4(1), Jan 2006

The authors have outlined the development of a patient-centered checklist generated from patient and caretaker concerns related to being prepared for discharge. The authors believe that discharge plans should include prompts for patients and their families to identify key concerns regarding daily life after discharge from a hospital. A six-month series of post-discharge interviews of elderly recently ill patients and their caretakers identified concerns relating to transport home, entry into the home, having food and effective heating and cooling systems, obtaining assistance in managing home and family responsibilities, navigating in home, accessing their doctor, shopping, paying bills, and regaining social contacts. Discharge planning is defined as the systematic identification and organization of services and supports to assist patients to manage in the community post-discharge.



28. **Authors:** Moss, J.E., Flower, C.L., Houghton, L.M., Moss, D.L., Nielsen, D.A., Taylor, D.M.
Title: A Multidisciplinary Care Coordination Team Improves Emergency Department Discharge Planning Practice
Source: MJA Vol 177, 2002

In July 2000, a Care Coordination Team (CCT) was created to address an increasing demand for hospital services at Royal Melbourne Hospital that was found to be caused by a shortage in aged-care beds and a need for post-acute care. The CCT was comprised of nursing and allied health personnel. The target population included frail elderly, those living alone, the homeless, those who frequently came to the emergency department, and those with drug and alcohol problems. 2532 patients were identified by triage staff using a risk screening tool. The CCT utilized a comprehensive risk assessment where priority was first given to those whom unnecessary or inappropriate admission could be prevented and then to those requiring complex discharge planning. The risk assessment involved "documentation of expected discharge date and destination, existing services and supports, and include[d] prompts for referral to internal and external health professionals" (Moss et. al, 2002, p. 428). The CCT discharge referral sources included 24/7 access to home services through a post-acute-care emergency department unit (which included home care, personal care, physiotherapy, occupational therapy, transport, and childcare), a homeless persons nursing program, and working relationships with other service providers. The CCT service was assessed after 12 months and found that significantly fewer patients were admitted and readmitted to the hospital, nearly half of the participants were discharged home with referrals to service providers, there was a lack of adverse events found after discharge, and staff, patients, caregivers, and community service providers responded that they were highly satisfied with the CCT when surveyed. The study identified variations in staffing levels, time constraints, resource limitation, and eligibility criteria as issues that may affect successful implementation of CCT services and discharge planning. The authors "recommend this model, and the extension of community support services, to assist in the disposition of patients after acute care in emergency departments" (Moss et. al, 2002, p. 431).

29. **Authors:** National Health Care for the Homeless Council
Title: Essential Tools for Discharge Planning
Source: <http://www.nhchc.org/discharge.html>

The National Health Care for the Homeless Council (NHCHC) presents a compilation of materials from the Massachusetts Housing and Shelter Alliance (MHSA) that document the strides made in Massachusetts in improving discharge planning as it relates to homelessness, and provide replicable models for communities. MHSA's major work was to document the connection between growing homelessness and discharges from public systems of care, to create resources to address the problem, and to develop a comprehensive strategy of homeless prevention that assures discharge to the community. The materials are organized into five sections: introduction and overview; assessment materials; collaborating with local stakeholders; exemplary policies and practices; and improving outcomes.



FOSTER CARE

1. **Authors:** Mears, D., Travis, J.
Title: The Dimensions, Pathways, and Consequences of Youth Reentry
Source: Washington, DC: Urban Institute, 2004. (Report: 36 pages)

In this report, the authors describe youth reentry from correctional facilities and its policy relevance to communities nationwide. Drawing from the insights and comments from the participants of a 2-day Youth Reentry Roundtable held in May 2003, they identify specific programming and policy challenges to youth reentry. The roundtable discussion operated along the premise that there are differences between youth reentry experiences and that this is largely due to a fundamental difference in the psychological development of individual youth as he or she transitions from adolescence to adulthood. The authors assert that successful transition from dependency into adulthood requires appropriate psychological development, which also requires supportive adults and opportunities. Moreover, the authors also emphasize the lack of systematic aftercare services, including educational and employment opportunities for youth as prominent challenges to successful reentry. The general strategy proposed is pre-release planning and services, longer-term re-integrative activities, and community involvement. The recommendations provided involve reorienting correctional facilities to focus on reintegration of youth, reentry programs that take into account the role of race/ethnicity, community coalitions to support reentering youth, and a national research and policy agenda to generate reentry strategies across the country amongst others. The authors illustrate various challenges and beginning strategies for youth reentry, but their theoretical premise of psychological development of youth does not always clearly support these. In general, a theoretical understanding of youth reentry research is lacking in this report, and more can be stated about the current obstacles/support within the correctional institutions for various reentry strategies.

2. **Author:** Mech, E.
Title: Foster Youths in Transition: Research Perspectives on Preparation for Independent Living
Source: Child Welfare 73(5):603-623, 1994. (Journal Article: 20 pages)

In this article, the authors discuss five studies that span from 1965 to 1991 to provide a picture of how foster youth might successfully transition to independency after care. As the child welfare caseload demographics changed in the mid-80's to include more adolescents in out-of-home care and public opinion produced more funding for extended care, these particular studies sought to address the interventions required to meet this changing need. The follow-up studies with former foster youths were conducted in interview format in person, phone, or mail, and measured five components: educational progress, employment status, living arrangements, family/social/community supports, and cost-to-community (reliance on public assistance). Of all the survey studies, only 58% of respondents achieved a high school diploma or the equivalency, which demonstrates a serious deficit in former foster youth's educational progress when compared to the 84% high school graduation rate within the general public at the time. The authors illustrate how this low educational attainment figure for the youth also translated to only half of them being employed full time, and of those employed full time most were at poverty level wages. Reliance on public assistance after care was also found to be significant. From the findings, the authors suggest a research agenda to cover all of the previously studied areas with the addition of research of caregivers as developmental resources and the involvement of youth in the planning process. While the authors admit that research in the area of understanding the transitional process of foster youth to independency is scarce, these particular studies should be compared to more current foster youth statistics and transitional programs in order to gauge in validity and relevance today.



3. **Author:** Zanghi, M., Detgen, A., Jordan, P., Ansell, D., Kessler, M.
Title: Promising Practices: How Foster Parents Can Support the Successful Transition of Youth from Foster Care to Self-Sufficiency
Source: Edmund S. Muskie School of Public Service, Casey Family Services, & the National Resource Center for Youth Services at the University of Oklahoma, Date (151 pages)

In this study, the authors aimed to identify the best practices for foster parents and agencies serving adolescent youth within independent living programs. The research project purposefully targeted those foster parents who have already successfully helped their foster youth transition from foster care to independency. The basis of this research began with contacting independent living coordinators and foster care managers nationwide who were then asked to identify 3-5 public and private agencies with a foster parenting component. The agencies represented all ten of the Department of Health and Human Services federal regions. Through surveys, interviews, and focus groups the study created 13 criteria for successful foster parents. These included personal attributes of parents such as the ability to define home boundaries for youth and advocate for the needs of the youth; having sufficient economic resources and valuing and supporting education; and having agency support services to name a few. It is the position of the researchers that best practices involve the youth in all steps of planning for their own independence. However, despite the comprehensive suggestions for best practices, the authors admit research limitations that considerably limit the ability to generalize the findings. A few such limitations are that the research is based on extremely small samples, 80% of the participating parents are White (and thus not reflective of the national demographic), and most parents have incomes over 40k.

4. **Author:** The Center for Health Training
Title: Reproductive Health Discharge Planning for Incarcerated Youth
Source: Seattle, Washington; Center for Health Training, Date (25 pages)

The Center for Health Training (CHT) sought to develop and implement a new reproductive health initiative to address the national health priorities of soon-to-be-discharged incarcerated youth. A one-day pilot project was conducted at McLaughlin Youth Center in Anchorage, Alaska, and Deschutes County Juvenile Community Justice Program in Bend, Oregon, in which staff from both correctional and community based agencies worked together to incorporate reproductive health information, services, and referrals into existing discharge planning services for youth leaving corrections. To evaluate the training CHT utilized feedback questionnaires at the end of the training and a qualitative post-training survey mailed to participants one month after. In comparison of the study results between both facilities, each gave the highest marks to the primary training objectives—identifying the reproductive health needs of adolescences and comparing correctional goals for youth with those of community based agencies. Finally, both correction and community agencies expressed that this pilot training project helped to forge increased communication between their programs working with the same youth. Some of the barriers to achieving training goals acknowledged by the authors are public opinion, legal ramifications, statutory restrictions, community agencies not being able to run the programs they wanted within correctional facilities, and correctional facilities wanting outside agencies to provide help. Certain further limitations to this study that should be acknowledged are the types of correctional facilities participating that are not necessarily representative of all, low response rates on the survey given a month later, lack of a thorough evaluation of any new intervention strategies resulting from the training, and the study only dealt with voluntary agencies.



5. **Author:** Bullis, M., Yovanoff, P., Mueller, G., Havel, E.
Title: Life on the "Outs" - Examination of the Facility-to-Community Transition of Incarcerated Youth
Source: Council for Exceptional Children, 69 (1): 7-22, 2002. (Journal article 15 pages)

This 5-year longitudinal study examines the facility-to-community transition experiences of youth who were incarcerated in the Oregon Youth Authority (OYA). This is done by using a prospective survey approach to: 1) analyze the outcomes of the sample 12-months after returning to the community and 2) look at the variables associated with successful transition throughout the 12 months. Of the 531 participants, about 58% were labeled as having a special education learning disability, 30% as emotionally disturbed, and 22% as learning disabled. The study sample was recruited for the first 3 years of the project. Once participants were secured, most were interviewed in person before they exited the facilities and again 6 and 12 months after leaving the facilities via the telephone. Of the notable findings, the sample in this study experienced low rates of involvement in school and work and moved frequently; individuals engaged in school or work at 6 months after reentry tended to remain engaged and out of the juvenile correctional system at 12 months; and incarcerated youth with special education disabilities fared worse than their peers without disabilities. The study findings support that a major service issue facing reentry youth are services that facilitate successful school and work outcomes and thus also may prevent recidivism. The results of the study may not be generalized to the OYA incarcerated youth population due to differences in age, sex, and disability type between study participants and the overall OYA special education population. Furthermore, the dependence on respondent reports and dropping unreachable clients from the potential respondent pool add to the limitations of the study findings.

6. **Author:** Leeuwen, J.V.
Title: Reaching the Hard to Reach: Innovative Housing for Homeless Youth through Strategic Partnerships
Source: Child Welfare 83 (5): 453-468, 2004. (Journal article 15 pages)

This article highlights the effectiveness of utilizing public, private, and non-profit agency collaborations to develop and fund homeless youth programs. Specifically, the homeless housing programs of youth shelter Urban Peak in Denver, Colorado utilized such public and private agency collaborations and experienced a significant increase of successful youth transitions to independence at one-tenth the cost of incarceration or residential treatment programs. One housing unit for example, Rowan Gardens, an apartment living program collaborated with the U.S. Department of Housing and Urban Development (HUD) to provide housing subsidies for the youth tenants. Guiding these programs are information gathered upon homeless youth through self-administered, anonymous, and voluntary surveys. The central approach of the agency is to identify public and private partnerships based upon the needs of the youth. According to the article data, there is considerable evidence for success in utilizing private and public agency collaborations in serving the needs of homeless youth. However, the article does not specify the terms of collaboration or suggest possible strategies for collaboration. Moreover, the article data illustrates the racial discrepancy between the homeless youth population and the general public of Colorado at large as well as between homeless youth and those homeless youth utilizing services, yet there is no mention of how current collaborations dealt with or intend to deal with these racial differences.



7. **Author:** Alliance Online News
Title: Homelessness and the Child Welfare System
Source: Washington, DC: National Alliance to End Homelessness, 2005

Speakers at the National Housing Conference noted that children in families who experience homelessness are more likely to be removed from families and placed into foster care than children in other low-income families. Further, that young people exiting foster care have high rates of homelessness. The Family Unification Program which connects housing subsidies and services for child welfare involved families and youth exiting care had a promising rate of success in families remaining housed. Also, 90% of families in which the children were at risk of placement into foster care remained together while 62% of families that had a child or children in care were reunified.

8. **Author:** Barth, R.
Title: On Their Own: The Experiences of Youth After Foster Care
Source: Child and Adolescent Social Work Journal 7(5): 419-440, 1990 (Journal Article: 21 pages)

In this article, the author studies the experiences of fifty-five former foster youth in San Francisco Bay Area, including Sacramento, who have been emancipated from one to ten years. The author found that members of the group were often struggling with ill health, poor education, severe housing problems, substance abuse, and criminal behavior. The article states that a sizeable number of the group suffered from headaches, dental, vision, weight, sleeping, drug or alcohol, sexual and hearing problems, depression, loneliness, thoughts of suicide, and vomiting, but only about one-third of those affected obtained treatment. The author concludes that the odds of moving easily into independence are stacked against foster children, and that foster youth need academic remediation and demonstrated problems in such areas as self-control, managing home and school learning demands, and peer and adult relationships (author).

9. **Author:** Wertheimer, R.
Title: Youth Who "Age Out" of Foster Care: Troubled Lives, Troubling Prospects.
Source: Washington, DC: Child Trends, 2002. (Brief: 8 pages)

In this brief, the author charts the trends in foster care, racial and ethnic disparities among the foster care population and characteristics of children in leaving the system. This research brief also offers program and policy options for reducing the number of children in foster care and supporting youth of all ages (authors).



10. **Authors:** National Coalition for the Homeless
Title: Homeless Youth
Source: Washington, DC: National Coalition for the Homeless, 2005 (Fact Sheet: 4 pages)

This fact sheet discusses the dimensions, causes and consequences of homelessness among youth. An overview of program and policy issues, and a list of additional resources for further study, is provided (authors). Youth become homeless mainly for three reasons; 1) family problems, 2) economic problems, 3) residential instability. In the long term, homeless youth would most benefit from the same measures that needed to fight poverty and homelessness for the adult population.

11. **Authors:** National Health Care for the Homeless Council
Title: Homeless Young Adults Ages 18-24: Examining Service Delivery Adaptations
Source: Nashville, TN: National Health Care for the Homeless Council, 2004 (Report: 42 pages).

This report is organized around four main topics: health care, housing, education and employment, and social support. In sections devoted to each of those topics, brief descriptions of service barriers are followed by recommended short and long-term strategies for overcoming them. Young adults in the U.S. are uniquely vulnerable to homelessness. Estimated numbers of young adults who experience an episode of homelessness each year range from approximately 750,000 to 2 million, and are believed to be increasing. This is a problem adulthood is a developmental state during which appropriate supports can make an especially important difference (authors).

12. **Author:** O'Brien, P.
Title: Youth Homelessness and the Lack of Permanent Relational Planning for Teens in Foster Care: Preventing Homelessness Through Relationship
Source: Brooklyn, NY: You Gotta Believe, 2004. (Report: 17 pages)

This report discusses the issues of youth homelessness, and the lack of relational planning for older foster care children. The author examines the number of youth who are homeless in New York City, and nationwide, and the relationships these youngsters lack as compared to youth who are not homeless. Suggestions are given on how to help youth live independently, and the author also dispels common myths about how youth become homeless (author). According to the author forty-nine percent of children with independent living goals had no plan in their record for living arrangements. The author argues in this article that youth emancipating from foster care are more at risk to homelessness because the child welfare system has not made it a priority to develop lasting permanent relationships for these youth. Thus, the author claims that relational planning can best mediate this gap by changing the structure of the current system focus on "independent living" to "interdependent living". This would be accomplished in four ways; 1) no longer allow youth to waive adoption, 2) Allow youth to continue eligibility for adoption even when independent living is chosen, 3) the child should have access to birthparents—even when the parents rights have been terminated, and 4) require that ILP's include relational planning as part of programmatic content.



13. **Author:** Rashid, S.
Title: Evaluating a Transitional Living Program for Homeless, Former Foster Care Youth
Source: Research on Social Work Practice 14(4): 240-248, 2004 (Journal Article: 9 pages)

In this article, the authors assess the outcomes of former foster care youth using transitional living programs and compare outcomes achieved by former foster care youth who participated in an employment training program with similar youth who did not. Based on a study that sampled twenty-three former foster care youth using transitional living services in Northern California, hourly wage, money saved, and employment status outcomes at discharge were examined. Housing outcomes were also examined six months post discharge. The article asserts that hourly wage, housing situation, employment, and money saved were among the variables that demonstrated improvement post intervention and at a six-month follow-up, and ninety percent of youth with known housing situations were in permanent, stable housing. The article concludes that transitional living and employment training programs may be effective interventions for former foster care youth with few resources.

14. **Author:** Mech, E.
Title: Uncertain Futures: Foster Youth in Transition to Adulthood
Source: Washington, D.C.: CWLA Press, 2003

The focus of this volume is on evaluating the progress of foster youth toward achieving self-sufficiency, describing societal efforts to respond to the needs of foster wards, analyzing an evolving national-level opportunity structure for youth in placement, identifying best practices and promising interventions, as well as recommending policies, programs, and services for the 21st century (author). Upon discharge 55% of foster care youth do not have a high school diploma; nearly one in three reported being poorly prepared to live on their own and having received some form of public aid.

15. **Authors:** Byrnes, M. Macallair, D., Shorter, A.
Title: Aftercare as Afterthought: Reentry and the California Youth Authority
Source: San Francisco, CA: Center on Juvenile and Criminal Justice, 2002 (Report: 54 pages)

This report highlights nine exemplary programs in seven states and the District of Columbia that have demonstrated success through collaborative, comprehensive services at a lower per-capita cost than incarceration and have resulted in improved public safety, lower costs, and positive investment in the future. While the specific elements of an effective reentry program may vary, the ultimate goal is the same: to preserve public safety, reduce recidivism, and assist individuals to achieve success (authors).



16. **Authors:** Osgood, D.W., Foster, M.E., Flanagan, C., Ruth, G.R.
Title: On Your Own Without a Net
Source: Chicago, Ill: The University of Chicago Press, 2005 (Book: 401 pages)

This book analyzes the experiences of foster youth as they attempt to make the transition of emancipation. The authors find that current policies often impede, rather than facilitate, the transition processes for these youths. The majority of these youths have extremely limited support systems, including family support, to help them through the difficult transition to adulthood. Currently, with exception of those young adults who have aged out of foster care and are entitled to “independent living” services, there is no system responsible for helping young adults experience substantial difficulties. The authors argue that this is a compelling need to create a similar system of support and opportunity for these youths and moreover, access to needed services may require involvement with multiple agencies. The youth must be fully involved in the decision making process, because after all, transition is a process not an event.

17. **Authors:** Zangrillo, P., Mercer, M.
Title: Housing and Foster Care: Results of a National Survey
Source: Washington D.C.: American Public Welfare Association, 1995. (Report: 78 pages).

The overall goal of the research is to create a better understanding of the nature, scope, and magnitude of the impact of housing on foster care entries and discharges in the country and to recommend models for policy and practice. The indications are the homelessness and inadequate housing is contributing to the troubling increases in foster care caseloads nationally. This may occur either because homelessness or inadequate housing is the sole reason or a contributing reason for removal of children into foster care, or because children remain in foster care when there is no adequate family home to which they might return. The report finds that a number of studies have pointed out that homeless shelters house a disproportionate number of individuals who have a foster care history or who were abused or neglected as children. The link seems to be especially strong for adolescents emancipated from foster care. The report makes the following recommendations, among others:

Clarifications, such as definitions of inadequate housing that constitute neglect and of necessary housing services, will promote a uniform understanding and implementation of laws and policies regarding housing and child welfare. Local housing officials should offer periodic help in training one or more local child welfare workers in: the available housing organizational resources in the community, the types of low-income housing programs available, current waiting lists, program contacts, and eligibility and application procedures for housing programs.

Collaboration should be encouraged between state and local housing organizations and child welfare agencies. Local lending institutions should assess the housing needs and resources in their communities and plan useful and innovative strategies for necessary improvements. Child welfare agencies should have their own flexible or locally supported funding resources or use AFDC-EA or other funding streams for speedier solution to housing problems, especially when family housing does not need to be totally replaced.

The federal government should take a leadership role in all of the above recommendations, and should continue its own coordination efforts between U.S. Departments of Health and Human Services (HHS) and HUD.



18. **Authors:** Shelter Partnership, Inc.
Title: A Report on Transitional Housing For Emancipated Youth in Los Angeles
Source: Los Angeles, CA: Shelter Partnership, Inc., 1997. (Report: 89 pages)

This report resulted from the need for detailed and reliable data regarding the services and housing available to emancipated foster youth. It examines the context in which current services and housing are being provided and offers some guidance for further action in addressing the needs of this population and focuses on the service and transitional housing needs of emancipated foster youth. According to DCFS, 45% of the youth emancipated each year become part of the homeless population of Los Angeles. The report identifies six service areas that are important for emancipated youth: case management; how to budget money; individual counseling; housing placement; job search assistance; and how to access health care. The report makes the following recommendations, among others:

Additional public and private resources for both capital and operating costs aimed toward serving the housing of the emancipated foster youth population need to be identified.

Transitional housing programs serving emancipated foster youth need to offer comprehensive services to ensure that the youth successfully transition to independence.

Additional housing for emancipated single parents with two or more children should be developed.

Additional housing services are needed for youth who emancipate through the Probation Department.

19. **Authors:** McCroskey, J.
Title: Youth in the Los Angeles County Juvenile Justice System: Current Conditions and Possible Directions for Change
Source: Los Angeles, CA: L.A. County Children's Planning Council, 2006.

The purpose of the report was to highlight and promote the importance of building partnerships—particularly with families, schools, and communities—to improve the outcomes of youth in L.A.'s juvenile justice system. A key lesson learned by the Children's Planning Council (CPC) was that in order for partnerships to be successful partners needed to clearly understand the challenges requiring the partnership, familiarity with relevant data, and visualization of concrete directions for change—a shared vision of success. The report outlines numerous success factors for change and improved outcomes. Some key factors are; centralized, integrated data and analysis systems, creation of a community continuum of care for youth, DCFS and DOP development of a successful model of dealing with dual jurisdiction issues and collaborative partnerships with community organizations, compilation of local resources for youth and their parents to empower and involve both in the successful transition back into the community.



20. **Author(s):** Ferguson, K., Dyrness, G., Miller, D., Dabir, N., Dortzbach, K.
Title: Innovative Programs Servicing Homeless and Street-Living Children Around the World
Source: Los Angeles, CA: USC Urban Initiative, 2005

The authors found that all the organizations they studied aimed to create an environment where street youth can learn to respect themselves, become more responsible, and adopt a more positive attitude. They further recommended that five elements be incorporated into the delivery of faith-based programs for homeless and street-living youth; 1) a faith component, 2) a family structure, 3) a flexible structure, 4) a holistic approach, 5) a collaborative approach. The authors also address the question of public funding for faith based organizations. Their recommendation was that government funding should be given to faith-based organizations, but those faith-based organizations must be culturally competent. According to the authors, this can be best accomplished by offering a variety of religious practices, regardless of the faith they originate from, alongside a general tolerance for all mainstream faiths and their rituals, and allowing the youth make the decision on their own.

21. **Author:** Hyde, J.
Title: From home to street: Understanding young people's transitions into homelessness
Source: Los Angeles, CA: Journal of Adolescence, 2005

This paper explores why young people leave home and become homeless. In professional discourses, homeless young people are often portrayed as victims of physical abuse and emotional neglect. However, many young people see things differently. The author explores the life history of young homeless people in Los Angeles and suggests that many view themselves as active agents in the events that led them from home to the streets. Regardless of the turbulent and often violent circumstances that underlie young people's decisions to leave home, many recounted these events in a way that allowed them to feel empowered.

22. **Authors:** Quotah, E., Chalmers, R.
Title: Transitional Living Programs Move Homeless Youth Closer to Independence
Source: Silver Spring, MD: National Clearinghouse on Families and Youth, 2006

In this article the authors survey components and strategies that make transitional living program more successful in helping homeless youth move closer to independence. Some strategies include fostering community ties, finding the right housing, and finding the right approach to managing the program. The article highlights the Runaway and Homeless Youth Act of 1988, which created the Transitional Living Program. Many homeless and runaway youth are victims of neglect, abandonment, or severe family conflict. Because of this lack of familial support to guide them to adulthood many homeless youth risk becoming involved in dangerous lifestyles.



PRISONS and JAILS

1. **Authors:** Nelson, M., Deess, P., Allen, C.
Title: The First Month Out: Post Incarceration Experiences in New York City
Sources: Vera Institute of Justice, 1999

This study followed 49 people released from New York State prisons and New York City jails for 30 days. This initial time is identified as a critical period where people are most at risk for re-entry into the jail system. Certain factors were identified among those who had more successful reintegration into society. The moment of release is a crucial time to engage people. Nighttime and unpredictable releases can make it hard for people to immediately access service, to connect with families, and can put them at risk for engaging in activities that put them at risk for return to prison. Family support is highly correlated with success after release in the first month. Families often provide material support such as housing and also emotional support. People who did not have family or friends to stay with had to find alternative housing such as shelters. Out of the 13 people who expected to stay in a shelter upon release for jail, eight dropped out of the study and were more likely to not follow up with parole. Finding a job is a major concern for the participants. Those more likely to get a job had prior experience, were under 40 years of age, and had stronger family support. Some college education also indicated a higher likelihood of securing employment. Those who got employed either got an old job back, used friends, or went a slower route and searched alone or used an employment program. Most former drug users stated that they stayed clean during the first month with reasons such as maintaining relationships, family, and parole supervision. Those who did not had one common denominator: weak family bonds. Majority of parolees found parole supervision to be useful as a deterrent for drug use and crime. The most consistent criticism was that parole officers did not assist them in finding a job. Participants who felt confident that they would not return to prison were doing well and had ties to family and friends. Most felt powerless in their environments. Most people were offered pre-release planning but satisfaction varied. Participants as well as parole officers identified certain areas that should be concentrated on for beneficial planning: job assistance; basic documentation; making necessary links with the health and mental health care systems; and connections with community service providers. It is suggested that these areas could be addressed in "pre-release" centers, such as at the Queensboro Correctional Facility, as part of a comprehensive method for preparing inmates for release.



2. **Authors:** Steinberg, D.
Title: AB 2034 Integrated Services for Homeless Mentally Ill
Sources: California Legislature, 2000 & AB 2034 Impact Statement January 2007

Assembly Bill 2034 is the expansion of AB 34 pilot program in 1999. AB 34 addressed the longstanding problem of the under funded community mental health care system and the consequences of severely mentally ill adults not getting treatment resulting in these adults being homeless, incarcerated in jails, and hospitalized. The pilot program was established in Los Angeles, Sacramento, and Stanislaus counties to provide extended community mental health services and outreach to mentally ill adults who are homeless or at risk of homelessness. The success of AB 34 in stabilizing and treatment of more than 1,000 people supported AB2034's request to permit additional counties that had or could develop adult system of care programs to have an opportunity to participate in these programs, based upon unmet needs, successful existing programs, and each county's capacity to increase services as well as allow the three pilot counties to continue expansion of programs based upon unmet need.

Funding increased from \$10 million to \$55 million to increase intensive community-based services for those who are mentally-ill, homeless, and who have a history of incarceration or are at high-risk of being incarcerated. Los Angeles County received \$18.25 million to expand services and treat more clients through an increase in contracted agencies.

Features of AB2034 are a low staff-to-client ratio, cultural competence, 24/7 staff availability, community-based services, housing and employment services, a focus on harm reduction, and collaboration with community agencies and members to better advocate and serve clients. AB 2034 was created to have measurable outcomes and some important findings are that there is a: 82% reduction in the number of clients homeless; 70% reduction in the number of days clients were homeless; 17% reduction in hospitalizations; 66% reduction in number of days hospitalized; 67% reduction in the number of incarcerations; 82% reduction in the days of incarceration; 164% increase in the numbers of consumers receiving SSI/SSDI. Based on the May 2006 reporting period 55% of clients lived independently in their own apartment; 17% were employed in paid positions; 11% worked more than 20 hours/week; and 8% attended school. AB 2034 is successful as an alternative method to treating and supporting clients who are difficult to engage and are on the fringe of society. The "whatever it takes" mentality is part of the programs success.



3. **Authors:** 108th Congress, 1st Session, Davis of Illinois
Title: HR 2166 The Public Safety Ex-Offender Self-Sufficiency Act, 2004
Sources: Thomas (Library of Congress); 108th Congress, May 20, 2003

A bill to amend the Internal Revenue Code of 1986 to provide for a temporary ex-offender low-income housing credit to encourage the provision of housing, job training, and other essential services to ex-offenders through a structured living environment designed to assist the ex-offenders in becoming self-sufficient. An "ex-offender" is defined as any individual who has been convicted of a crime under State or Federal law which is punishable by imprisonment for a maximum of 6 months or longer. A tax credit will therefore be offered to those who own buildings that meet specified requirements. All or some of residential units in a building must be single room occupancy; any unit available to ex-offenders must be made available to ex-offenders children. A self-sufficiency center should be designed for ex-offender support services. Rent amounts may not exceed 30 percent of a renter's adjusted income. Ex-offenders must meet residency requirements such as having low income and participating in support services. The limit of stay is 2 years after beginning of occupancy.

4. **Authors:** Community Shelter Board
Title: Preventing Homelessness: Discharge Planning from Corrections Facilities
Source: Columbus, OH: Community Shelter Board, 2002 (Report: 13 pages)

This report discusses the reasons for prevention and discharge planning, as well as explores the housing barriers to successful reentry and the lack of benefits for people who are mentally ill. The authors define discharge planning, and give examples of what can be done to prevent homelessness. Innovative community programs are discussed, such as the Fortune Society, Safer Foundation, Project Return, and Druid Heights Transitional Housing for Ex-Offenders. The authors also give a sampling of policy initiatives from different states, including Massachusetts, Illinois, Ohio and Minnesota (authors). Available From: Community Shelter Board, 115 West Main Street, LL, Columbus, OH 43215, (614) 221-9195, www.csb.org.

5. **Authors:** Osher, F., Steadman, H.J., Barr, H.
Title: A Best Practice Approach to Community Re-entry from Jails for Inmates with Co-occurring Disorders: The APIC Model
Source: Delmar, NY: The National GINS Center, 2002 (Manuscript: 20 pages)

Almost all inmates with co-occurring mental illness and substance use disorders will leave correctional settings and return to the community. Inadequate transition planning puts people with co-occurring disorders who enter jail in a state of crisis back on the streets in the middle of the same crisis. The outcomes of inadequate transition planning include the compromise of public safety, an increased incidence of psychiatric symptoms, relapse to substance abuse, hospitalization, suicide, homelessness, and re-arrest. While there are not outcomes studies to guide evidence-based transition planning practices, there is enough guidance from the multi-site studies of the organization of jail mental health programs to propose a best practice model. This manuscript presents one such model—APIC. The APIC Model is a set of critical elements that, if implemented, are likely to improve outcomes for persons with co-occurring disorders who are released from jail (authors).



6. **Authors:** Hals, K.
Title: From Locked Up to Locked Out: Creating and Implementing Post-Release Housing for Ex-Prisoners
Source: Seattle, WA: AIDS Housing of Washington, 2003 (Report: 170 pages)

This is a report about the tragedy of homelessness among exiting prisoners. It is written for anyone who believes in building and filling more homes for ex-prisoners instead of more jails to which they can return when homelessness, among other problems, sends them on a U-turn back to lock-up. It is starting point for planning post-release housing and related services to support the transition out of prison. It is also written to improve housing programs where ex-prisoners now live but, perhaps, do not fit in or succeed. This book also intends to dispel fear. Housing providers with minimal experience in the field of criminal justice often have anxiety about serving ex-prisoners. In response, the book explains who today's prisoners really are and the degree to which many belong more to the mainstream of society, even if to its most unfortunate tributary, than a subgroup of sociopaths. Also explained are the dynamics of prison life, the experience of coming back to society, and how helpers who have not been behind bars themselves can learn to relate to those who have. Throughout, the book presents examples of post-release housing and related services. It shares the opinions of concrete to the philosophical, about how to create and implement such programs.

7. **Author:** Hausman, K.
Title: Mentally Ill Inmates Win Right to Discharge Planning
Source: Psychiatric News 28(6): 21, 2003. (Journal Article: 1 page)

This article discusses the outcome of the class-action lawsuit against New York City, to mandate the provision of a discharge-planning for mentally ill inmates. To settle the suit against it, New York City agreed to implement a comprehensive discharge-planning program that will follow mentally ill inmates into the community. Before it decided to settle the case, the city lost two appeals of a July 2000 ruling by a state trial court that ordered the city to begin such a program. The suit against the city argued that while city law mandates discharge planning that provides continuity of care for inmates receiving mental health care, the city routinely sends inmates back to the community with no post discharge agreements in place.

8. **Authors:** Rodriguez, N., Brown, B.
Title: Preventing Homelessness Among People Leaving Prison
Source: New York, NY: Vera Institute of Justice, 2003. (Report: 12 pages)

This report examines homelessness among former inmates, shares examples of corrections agencies' efforts to address it, and offers insights from the Vera Institute's Project Greenlight, an in-prison program that provided comprehensive transition services, including housing assistance, to felony offenders reentering communities in New York City. Included are details on Project Greenlight's housing assistance program and suggestions for practitioners interested or engaged in similar efforts (authors).



9. **Authors:** Community Shelter Board
Title: Preventing Homelessness: Discharge Planning from Corrections Facilities
Source: Columbus, OH: Community Shelter Board, 2002 (Report: 13 pages)

This report discusses the reasons for prevention and discharge planning, as well as explores the housing barriers to successful reentry and the lack of benefits for people who are mentally ill. The authors define discharge planning, and give examples of what can be done to prevent homelessness. Innovative community programs are discussed, such as the Fortune Society, Safer Foundation, Project Return, and Druid Heights Transitional Housing for Ex-Offenders. The authors also give a sampling of policy initiatives from different states, including Massachusetts, Illinois, Ohio and Minnesota (Authors).

10. **Author:** Barr, H.
Title: Prisons and Jails: Hospitals of Last Resort. The Need for Diversion and Discharge Planning for Incarcerated People with Mental Illness in New York.
Source: New York, NY: The Correctional Association of New York and the Urban Justice Center, 1999. (Report: 54 pages)

This article states that deinstitutionalization and the closing of psychiatric hospitals, the rise managed care, the growth of prisons and jails, and punishment of "quality of life" crimes have contributed to the incarceration of thousands of people with mental illness in New York City and New York State. This report examines the scope of the problem and recommends strategies which, if implemented, would lead more humane and sensible system. In such a system, seriously mentally ill minor offenders would be diverted to treatment rather than sent to jail, and prisoners requiring mental health services would be able to continue their treatment as they moved between correctional facilities and the community. The author states these strategies have the potential to be safer and cheaper for the community while providing better care for people with mental illness (author).

11. **Authors:** Metraux, S., Culhane, D.P.
Title: Recent Incarceration History Among a Sheltered Homeless Population
Source: New York, NY: Corporation for Supportive Housing, 2004 (Unpublished Paper: 39 pages)

This study examined incarceration histories and shelter use patterns of 7,022 persons staying in public shelters in New York City. Through matching administrative shelter records with data on releases from New York State prisons and New York City jails, 23.1% of a point-prevalent shelter population was identified as having had an incarceration within the previous two-year period. Persons entering shelter following a jail episode (17.0%) exhibited different dynamics are predominant and different interventions are called for among shelter users released from jail and from prison (authors).



12. **Authors:** Hughes, T., Wilson, D.J.
Title: Reentry Trends in the United States
Source: Washington, D.C.: U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics, 2002 (Report: 27 pages)

This report provides statistics pertaining to inmates returning to the community after serving time in prison. The authors present information on reentry trends in areas such as growth in State prison and parole populations, releases from State prison, entries to State parole, success rates for State parolees, recidivism, terms used. The report concludes with a description of data sources and a list of relevant reports produced by the Bureau of Justice Statistics.

13. **Author:** Baca, L.
Title: Los Angeles Sheriff's Department Homeless Advisory Committee Report
Source: Los Angeles, CA: Los Angeles Sheriff Department, 2003

The report is a compilation the work of LASD over the past three years regarding homelessness in Los Angeles and in the Los Angeles County criminal justice system. The report finds that law enforcement, by default, has become the care taker of last resort for many homeless and L.A. County jail is one of the largest mental health hospitals and service provider in the nation. According to the report 350-500 people are released from jail and 10% have no place to go and are considered homeless. The report finds several service needs for Los Angeles, as well as, makes several recommendations and actions on how to address the problems of homelessness. Some examples are to reconsider public policy priorities to prioritize and address homelessness, and restructure funding to better deal with the problem and developing programs that use volunteers to help intercept and assist homeless individuals find programs that will help them become self sufficient.

14. **Author:** Tousignant, M
Title: Criminal Background and the Admissions Process: A Review of Management Policies Among Affordable Housing Providers in Los Angeles County
Source: Los Angeles, CA: Shelter Partnership, 2005

The link between stable housing and has garnered increasing attention among policy makers who are under pressure to pursue cost-effective alternatives to expensive episodes of incarceration, emergency room visits, and psychiatric hospitalization. The study examined the need for affordable housing by those who are most vulnerable—particularly those who are discharged from the criminal justice system. The author argues that with the overwhelming demand and limited supply of affordable housing, the stigma of a criminal record, not to mention a history of jail or prison time, remains a significant barrier to housing. Many ex-offenders require a wide range of supportive services to enable them to be self-sufficient and maintain their housing. Thus, any solution must focus on advocating that local housing authorities consider easing their approach to applicants with criminal histories during eligibility determinations.



15. **Authors:** Krisberg, B., Waugh, M.
Title: Reengineering Reentry
Source: Oakland, CA: The National Council on Crime and Delinquency, 2006

In California the number of released prisoners has increased in California more than any other state in the nation. Aggressive incarceration without effective reentry programs is inhumane for the prisoner, unsafe for our communities, and extremely expensive for all taxpayers, according to the authors.

The article claims that successful reentry depends on having a system of services—housing, jobs, mentoring, meals, addiction treatment and mental health services—in place and immediately available to prisoners returning home. The NCCD is currently piloting a project where the goal is to reduce recidivism by providing a system of services. The project establishes an employment centered network of services that is facilitated by a team of transition coordinators.

16. **Authors:** Roman, C.G., Travis, J.
Title: Taking Stock: Housing, Homelessness, and Prisoner Reentry
Source: Washington, D.C.: Urban Institute, 2004 (Report: 101 pages)

Over the past generation, the U.S. has placed greater reliance on incarceration as a response to crime. This has led to far more people ending up behind bars for longer periods of time and very few having participated in education and drug treatment programs. In addition, a large proportion of released prisoners return to a small number of disadvantaged communities. The report is the culmination and synthesis of three tasks designed to inform the state of knowledge around housing, homelessness, and prisoner reentry: 1) a descriptive report on the barriers and challenges facing returning prisoners, as well as potential opportunities for serving or supporting the housing-related needs of returning prisoners, 2) a scan of promising housing and other housing-related service programs for returning prisoners and ex-offenders, and 3) a roundtable discussion by experts in the field held in Washington, D.C. on October 30, 2003.



17. **Authors:** Kushel, M. B., MD, Hahn, J.A., PhD, MPH, Evans, J.L., MS, Bangsberg, D.R., MD, MPH, Moss, A.R., PhD.
Title: Revolving Doors: Imprisonment Among the Homeless and Marginally Housed Population
Source: American Journal of Public Health 95 (10): 1747-1752, 2005 (Journal Article: 6 pages)

In this article the authors questions whether homeless persons who had a history of imprisonment would have higher rates of substance abuse disorders, mental health disorders, physical health problems, and illegal activities than those who did not have a history of imprisonment. Their analysis is based on the reasoning that people who are homeless at the time of arrest are overrepresented in prisons and homeless populations include higher proportions of former prisoners compared with the general population. The authors find that those who had been imprisoned were more likely to have a history of psychiatric hospitalizations, drug use, multiple sexual partners, and HIV infection than those who had not been imprisoned. Furthermore, the association between homelessness and imprisonment is complex because of shared risk factors and casual pathways in both directions. The authors conclude, despite high levels of health risks among all homeless and marginally housed people, the levels among the former prisoners were even higher. Efforts to eradicate homelessness also must include the unmet needs of inmates who are released from prison.

18. **Authors:** Bolaños, M.F., Esq., Emerman, A.
Title: Oversight Hearing: Tour of Rikers Island Discharge Planning Facilities and Services for Inmates with Psychiatric Illnesses
Source: New York, N.Y.: New York City Council: Committee on Mental Health, Mental Retardation, Alcoholism, Drug Abuse, and Disability Services, 2002 (Report: 3 pages)

The Committee on Mental Health, Mental Retardation, Alcoholism, Drug Abuse, and Disability Services participated in a tour of the Rikers Island Correctional Facility. The purpose of the visit was so that the committee could view the discharge planning facilities and service provided to inmates with psychiatric illnesses. At the time Rikers Island admits approximately 117,000 inmate annually and approximately 42% of those convicted and who suffer from mental illness are sent to forensic psychiatric centers located in upstate New York, such as the Mid-Hudson facility. In addition the discharge planers at Rikers use the "LINK" program to refer inmates for mental health services as part of their discharge plan, which includes the clinics at FEGS and Fordham-Tremont in the Bronx.



19. **Authors:** Moseley, J., MPH, Gordon, C., PhD, Murrill, C., PhD, MPH, Torian, L., PhD
Title: An Evaluation of Discharge Planning and Community Case Management Services for Incarcerated Adult Males at Rikers Island: *Correction Case Management at Rikers Island (CCARI)*
Source: New York, N.Y.: New York City Department of Health and Mental Hygiene, 2005.

The goal of the CCARI is to reduce recidivism and improve social functioning and community integration of adult males released from Rikers Island through discharge planning and case management. Those who had discharge planning and case management were less likely to have been homeless than those who did not have access to those services. In addition the need for housing was still the number one priority, but less so for those who had access to discharge planning and case management. Despite these positive indicators, researchers found that some challenges still arose to successful reentry. Some of the challenges ex-offenders face when exiting the facility were the changes in priorities for inmates once released from jail—i.e. familial problems—and the inability of some referrals to meet the immediate needs once released from jail—i.e. transportation to appointments.

20. **Author:** Rodriguez, J., CATC, CADC II
Title: Custody to Community: Housing Offenders
Source: Los Angeles, CA: Tarzana Treatment Centers, 2006

California has the largest prison system in the nation and Los Angeles County has the largest jail system in the nation. In addition, Los Angeles County is also the largest county with the most new admissions, parole violators, and parole violators with new terms to the California Department of Corrections and Rehabilitation (CDCR). The purpose of this booklet is to provide basic information on the criminal justice system and population with emphasis on the chemically dependent offender that recycles through custody and community after unsuccessful integration to society. Readers will learn useful terminology and techniques to strengthen offender and staff rapport. The author provides step by step strategies for agencies and their staff to be successful in reducing recidivism in their communities.

21. **Author:** Steadman, H.J., PhD.
Title: Recent Developments in Jail Diversion
Source: Alexandria, VA: National Association of State Mental Health Program Directors, 2005

In 2003, there were 12.5 million jails in the United States. Of those 12.5 million admissions 886,000 suffered from a severe mental disorder. By and large offenders with a severe mental disorder also suffer from a co-occurring disorder. The basic goals of jail diversions is to keep people out who do not need to be there and to link people to services to keep them from coming back (because of mental illness). The author highlights the Nathaniel Project (NYC) which had been successful in keeping ex-offender housed. At intake 10% of ex-offenders had housing while at one year 79% were housed. At 6 months and 2 years the program had a retention rate between 80 and 90 percent.



22. **Authors:** Re-Entry Policy Council
Title: Report of the Re-Entry Policy Council: Charting the Safe and Successful Return of Prisoners to the Community
Source: New York, N.Y.: Council of State Governments, 2006 (Report: 648 pages)

The Re-Entry Policy report provides hundreds of recommendations that focus on people who have been sentenced to either prison or jail and suggest elements of policies, programs, or legislation that address people after they have been sentenced. The report cites that nearly 650,000 people are released annually from prisons in this country. In addition, research shows that when people are released from prison or jail return to the community, their job prospects are generally dim, their chances of finding their won place to live are bleak, and their health is typically poor. Thus, the report makes key policy recommendations to assist advocates, policy makers, community members and service providers in crafting an initiative the helps communities successfully overcome the challenges of reentry.

This Report asserts that planning and preparation for re-entry should be an ongoing process beginning on the first day of incarceration. In addition, the authors emphasize the importance of planning for long-term reintegration. In the area of discharge planning the report outlines key policy areas to prepare and manage the transition period; they include, facilitating a person's access to stable housing, prepare community-based health and treatment providers, prior to the release of an individual, creation of employment opportunities, workforce development, preparing victims, families, and communities for their return, identification and benefits, design of supervision strategy.

23. **Authors:** Travis, J., Solomon, A.L., Waul, M.
Title: From Prison to Home: The Dimensions and Consequences of Prisoner Reentry
Source: Washington, D.C.: Urban Institute, 2001

In this report, the authors describe the reentry process, the challenges for reentry, and the consequences of reentry along several key dimensions. Prisoner reentry carries the potential for profound collateral consequences, including public health risks, disenfranchisement, homelessness, and weakened ties among families and communities. Thus the authors consider the costs and opportunities and the questions they raise about what can be done to prepare both ex-prisoners and their communities for their inevitable return home. Their assessment suggests that the ultimate goal of prisoner reentry is best conceptualized as social reintegration, not just reductions in recidivism. This view also envisions a new partnership of public and private entities that have an interest in improving those outcomes; not only out of concern of the former prisoners, but out of concern for those whose well-being is affected by the dynamics of their transition from prison to community.



24. **Author:** Carlisle, J.
Title: The Housing Needs of Ex-prisoners
Source: York, U.K.: Centre for Housing Policy, 1996

Although many prisoners had been inadequately housed before going to prison, the great majority wanted to retain their original homes. On release, however, less than half were able to return to their previous home. Three factors were instrumental in determining whether ex-prisoners succeeded in retaining their homes: the quality of family relationships, the availability of housing benefit, and their financial status. In the study, the author found a number of barriers to re-housing prisoners including; access to independent, mainstream accommodation, arranging accommodation other than in hostels prior to release is very difficult, and very few ex-prisoners agree to live in a hostel because of concern of being in contact with other ex-offenders. Complicating the picture, many ex-prisoners had to cope with the loss of their home, their partner and their job as they attempted to become rehabilitated into the community.

25. **Authors:** Osborne, J., Solomon, A.
Title: Jail Reentry Roundtable Initiative: Meeting Summary
Source: Washington, D.C.: Urban Institute, 2006

The article summarizes the meeting of the Jail Reentry Roundtable held by the Urban Institute. The purpose of the discussion focused its attention on those 12 million individuals released from local jails each year and brought together leading jail administrators, researchers, corrections and law enforcement professionals, county and community leaders, service providers, and former inmates to discuss the unique dimensions, challenges, and opportunities of jail reentry. Informing the Roundtable discussion were a set of papers that focus on the following jail reentry issues: inmate challenges, short-term interventions, community supervision, evidence-based reentry practices in the jail setting, reentry from jails for females, the economics of jail reentry, jail to community linkages, and reentry from rural jails. Some outcomes of the meeting included a vision of reentry as a system improvement process involving many different participants, partners, and outcomes that can be combined to solve complex problems.

26. **Author:** Petersilia, J.
Title: When Prisoners Return to the Community: Political, Economic, and Social Consequences
Source: Washington, D.C.: National Institute of Justice, 2000 (Article: 8 pages)

The numbers of returning offenders dwarf anything known before, the needs of released inmates are greater, and corrections have retained few rehabilitation programs. A number of unfortunate collateral consequences are likely, including increases in child abuse, family violence, the spread of infectious diseases, homelessness, and community disorganization. The phenomenon may affect the socialization of young people, the power of prison sentences to deter, and the future trajectory of crime rates and crime victimization. This presents formidable challenges for policymakers. Given the increasing human and financial costs of prison—and all the collateral consequences parolees create for their families, victims, and communities—investing in effective reentry programs may be one of the best investments we make. (Authors)



27. **Author:** McBride, N.
Title: Reaching In to Help Out
Source: Nashville, TN: National Health Care for the Homeless Council, Inc., 2004

Continuity of care—primary health care, mental health services, substance abuse treatment, housing, and entitlements—for individuals newly released from correctional facilities is a critical element in helping inmates successfully transition back into the community, thus breaking the cycle of recidivism. It is estimated that as many as 700,000 adults entering jails each year have active symptoms of serious mental illness and three-quarters of these individuals meet criteria for a co-occurring addictive disorder. Transition—or discharge—planning acknowledges the need for effective post release care and requires a commitment from community health providers as well as jail staff and administrators. By collaborating to support continuity of care—primary, mental health and substance abuse services—as people move from jail to the community, jails and community-based health care providers can help reduce the likelihood of recidivism. As different as their interventions are, community based health agencies and local jails still share a common goal: to reduce the cycle of recidivism by supporting continuity of care, collaboration is best applied at the critical juncture of transition from jail to community.

28. **Authors:** Baldry, E., McDonnell, D., Maplestone, P., Peeters, M.
Title: Ex-prisoners and Accommodation: What Bearing do Different Forms of Housing Have on Social Reintegration for Ex-prisoners?
Source: Melbourne, AU: Australian Housing and Urban Research Institute, 2002

The importance of suitable accommodation for persons being released from prison in relation to their chances of successful social integration has been highlighted in the few reliable international studies available on the matter. The paper is largely a literature review in relation to a research project exploring the relationship between ex-prisoners' social reintegration and housing in New South Wales and Victoria slated for release in July 2002. The few studies that have looked at the relationship between social issues and difficulties amongst prisoners (such as homelessness, mental disturbance, intellectual disability, drug abuse), and post-release experience have indicated consistently a high level of difficulty in securing suitable accommodation upon release. There is almost total agreement that housing, in particular supported accommodation is a crucial factor in assisting ex-prisoners in their post-release period. The level of recidivism indicates, at least, that a majority of prisoners have not reintegrated into society in a way that has enabled them to avoid re-incarceration.



29. **Authors:** Office of Justice Programs
Title: Serious and Violent Offender Reentry Initiative
Source: Washington, D.C.: U.S. Department of Justice, www.reentry.gov, 2003

The Serious and Violent Offender Reentry Initiative (SVORI) was established by the US Departments of Justice, Labor, Housing and Urban Development, and Health and Human Services in 2003. SVORI is a large-scale program providing over \$100 million to 69 grantees to develop programming, training, and state-of-art reentry strategies at the community level. The initiative is designed to address three strategies an offender goes through when returning to the community. The process involves three parts; 1) education, parenting instruction, vocational training, treatment and life skills programs while prisoners are in institutions, 2) services and supervision as they reenter the community, and 3) networks of agencies and individuals to support offenders as they become productive and law-abiding members of their communities. SVORI programs are intended to reduce recidivism, as well as improve employment, housing, and health outcomes of participating released prisoners.

30. **Author:** Steigman, D.
Title: Promising Practices in Home and Community-Based Services
Source: Baltimore, MD: Centers for Medicare & Medicaid Services, 2003 (Article: 3 pages)

The Miriam Hospital in Providence, Rhode Island, operates an intensive case management program for people with Human Immunodeficiency Virus (HIV) who are leaving prison. The 18-month program improves continuity of care following prison release by providing social services support and addressing barriers to medical care. A two-person team, consisting of an outreach worker and a social worker, approach potential participants approximately 60 days prior to release, and develop a treatment plan. Upon release, the social worker and outreach worker help ensure the participant makes it to this medical appointments by providing phone call reminders and transportation to medical appointments. The two-person team also helps participants navigate the social service system. An evaluation by Boston University found that overall the program contributed to the quality of life of the participants by providing stability to people and tackling their medical and social service needs.

31. **Author:** Visher, C.A.
Title: Effective Reentry Programs
Source: *Criminology and Public Policy* 5 (2) 299-302, 2006 (Article: 4 pages)

In recent years, policy makers and practitioners have become aware of the importance of research in determining 'what works' in correctional programming. The author responds to findings of a rigorous evaluation of an evidence-based reentry program, *Project Greenlight* in New York State. Visher finds that many lessons can be learned from *Project Greenlight's* design, implementation, and evaluation; 1) if an intervention is poorly conceived and/or poorly implemented, the program is unlikely to be successful, 2) even negative results can inform policy and practice, and 3) the results should encourage public and private funders to build on the *Project Greenlight* experience and support other reentry programs and their evaluations. The author strongly argues that the time is ripe for researchers and practitioners to work together to design and test innovative, research-based reentry programs.



32. **Authors:** National Alliance to End Homelessness
Title: Community Snapshot: Portland and Multnomah County
Source: Washington, D.C.: National Alliance to End Homelessness, 2007 (Article: 2 pages)

Over the course of a year, approximately 18,000 people experience homelessness in Portland and Multnomah County. Between 1999 and 2004 a number of initiatives were implemented to change the homeless assistance program, one key initiative being discharge planning. Portland and Multnomah addressed discharge planning in three ways; 1) jail discharge homeless prevention program, 2) transition immediately after inpatient care, and 3) providing recuperative care to homeless frequent users. These programs combined helped a total of 165 people find housing and services. As a result of discharge planning initiatives and other initiatives—such as, housing first, outreach, prevention, and employment—overall homelessness in Portland has decreased by 13 percent from 5,103 in 2005 to 4,456 in 2007.

33. **Authors:** The Criminal Justice / Mental Health Consensus Project
Title: Advocacy Handbook: A Guide to Implementing Recommendations of the Criminal Justice / Mental Health Consensus Project
Source: New York, N.Y.: Council of State Governments, 2006

The Criminal Justice / Mental Health Consensus Project is a how-to guide for advocates that want to improve the response to people with mental illness who are in contact with the criminal justice system. The handbook examines five crucial steps that should underlie any advocacy effort to reverse the overrepresentation of people with mental illness in the criminal justice system; and are as follows, 1) understand the issue, 2) anticipate frequently asked questions, 3) identify and know your audience, 4) take action, 5) leverage resources. This handbook targets advocates because, though they may be knowledgeable about how criminal justice involvement affects an individual with mental illness, they may be less than familiar with the processes and protocols of that system.

34. **Authors:** Osborne, J., Solomon, A.
Title: Jail Reentry Roundtable Initiative
Source: Washington, D.C.: Urban Institute, 2006

The article summarizes the meeting of the Jail Reentry Roundtable held by the Urban Institute. The purpose of the discussion focused its attention on those 12 million individuals released from local jails each year and brought together leading jail administrators, researchers, corrections and law enforcement professionals, county and community leaders, service providers, and former inmates to discuss the unique dimensions, challenges, and opportunities of jail reentry. Informing the Roundtable discussion were a set of papers that focus on the following jail reentry issues: inmate challenges, short-term interventions, community supervision, evidence-based reentry practices in the jail setting, reentry from jails for females, the economics of jail reentry, jail to community linkages, and reentry from rural jails. Some outcomes of the meeting included a vision of reentry as a system improvement process involving many different participants, partners, and outcomes that can be combined to solve complex problems.

